Rhode Island Community Planning Group for HIV Prevention

Comprehensive HIV Prevention Plan

Five-Year Plan
2005 – 2009

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Introduction

The Rhode Island community planning process for HIV prevention has moved into a new, exciting phase of development. Recognizing our accountability for the changes in the Centers for Disease Control and Prevention's (CDC) guidance around the cooperative agreement and the comprehensive plan, the Rhode Island Department of Health (HEALTH-RI) and the Rhode Island Community Planning Group for HIV Prevention (RICPG) have instituted several structural and procedural changes that will allow us to make ever-greater progress during these changing times.

Consultant Collaborative

As a result of isolating the need for a new, improved system of operation for the RICPG, HEALTH-RI during the past year issued Requests for Proposals (RFPs) from consultants across three major areas related to the community planning process. Our intention was to create a consultant collaborative that would assist the RICPG and HEALTH-RI in the major elements of community planning and HIV prevention. Requests for Proposals were solicited for the following areas:

1. **Facilitation and coordination of the community planning process—**This area encompasses both the logistical coordination and coalition-building of the RICPG. The consultant chosen to execute this component is a small agency named UpTyme, whose director, Lorraine Kaul, comes with years of coalition-building experience and is particularly well-versed and credentialed in the prevention field.

2. **Technical writing and social marketing of the community planning process—** This component involves creating and executing a communications plan for the RICPG. It requires expertise in transforming complicated information into something easily understood and usable, as well as enhancing the RICPG's visibility in Rhode Island. The consultant chosen to execute in this area is the Clarendon Group, a Providence-based firm led by Christine Heenan that has extensive experience in communications, government relations, and public policy. The Clarendon Group's work includes

advancing the RICPG's visibility among HIV prevention and care providers, policy makers, and the general public; drafting the RICPG Plan; and creating a series of workbooks for the RICPG.

3. **Capacity building—**This component involves coordination of Rhode Island's capacity-building initiative, known as Project REACH. The consultant chosen to execute in this area is the Drug and Alcohol Treatment Association of Rhode Island (DATA). As the administrator of a successful substance abuse training facility, DATA is well-qualified to manage and coordinate the activities associated with REACH. DATA's work includes facilitating the RICPG committee that focuses on the capacity-building issues facing the RICPG and local community-based organizations and working with HEALTH-RI staff to provide training and development for HIV prevention vendors funded by HEALTH-RI.

Workbooks

RICPG meeting evaluation forms reveal that the new, improved community planning has yielded positive results. Many RICPG members are pleased with the professional facilitation of the RICPG and are enjoying the organized approach that the workbooks have encouraged. Indeed, one member commented that the workbooks are the best thing that has happened to the RICPG, because they keep the group focused and on schedule and remind the group of its accomplishments. Members have also appreciated that the workbooks provide a means of documenting the accomplishments of committees and task forces.

Perhaps the most important contribution of their workbooks is the clarity and purpose they provided for the group. To date, workbooks have been produced in the following areas:

- Prioritization
- Best Practices
- Strategic Planning—Committee Work and CDC Attributes
- Community Empowerment—Committee Work and CDC Attributes

- Capacity Building—Committee Work and CDC Attributes
- Target Populations—RICPG Task Force Workbook

Governance and Coalition-Building

The structural elements of the RICPG have been challenged again this year, resulting in the introduction of amendments to the RICPG Charter by the Community Empowerment Committee, which is charged with responsibility for the Charter. Rules governing how the group conducts business have been the focus of attention and coalition-building. Focusing the group's attention on the importance of the latter, the RICPG facilitator has provided coalition-building training and development for the group. And a recruitment process is underway to appoint new members.

Our emphasis on coalition-building has generated a productive environment for approaching group dynamics and has set the stage for a more productive RICPG. Improved member accountability; clearer expectations of members' roles; a new emphasis on distilling complex information into easily understood, implementable pieces; the creation of a clearer, more precise way of approaching the RICPG "business"; and a movement toward developing a community response to HIV prevention through models of change are just some of the outputs we have observed this year.

The RICPG has adapted well to shifts in the planning process have occurred this year, including changes at both the national level (e.g., new CDC guidance, a shift in target population priorities, etc.) and local level (e.g., new RICPG consultants, shifts in membership, etc.). HEALTH-RI, the RICPG membership, and the RICPG consultants are confident that the RICPG will continue to adapt to these challenges and, indeed, use them to catalyze their work. We are confident that those who review our process in Rhode Island will agree that the RICPG is an increasingly organized planning body that is focused and committed to its important work.

Section 1
Goals & Objectives

In the late summer of 2002, the RICPG restructured its committees to further develop leadership in the group, increase member participation in the planning process, and apportion the work of the group in a more logical and strategic manner. The three standing committees—Community Empowerment, Strategic Planning, and REACH/Capacity Building—created a document establishing a standing meeting time, overall goals and areas of concern, and specific issues to be addressed by the committee. Implementation of this strategy, with revisions identified during the implementation process, has been ongoing.

Each of the three committees is responsible for a portion of the RICPG's goals and objectives. Their work is discussed below.

The Committees

Community Empowerment Committee

The Community Empowerment Committee is responsible for Goal 1, Objectives A, B, and C, and Attributes 1–18. The Committee's ongoing efforts focus on recruitment and retention of members, and improving the overall efficiency of the RICPG.

For example, the Community Empowerment Committee's work will include a discussion about preserving the confidentiality of HIV-infected members and members within other priority populations. When people are recruited because they have insights and/or experiences that other members may not have, there is a risk of breaching confidentiality in certain settings. The situation requires sensitivity around inclusion, parity, and cultural competence that may not be an issue in other community groups. The balancing of such issues is the charge of the Empowerment Committee, and it is a charge that the Committee takes very seriously.

Recruitment

Recruitment is going well, with the addition of five new members since January 2004.

Youth

The Committee has further charged itself with filling the gaps of representation in the current membership, having agreed that settling for minimal compliance was not an option.

The struggle to recruit and include youth members in a meaningful way continues. The RICPG does have youth-serving agencies as members, but the Community Empowerment Committee is interested in building the capacity of the RICPG to bring youth on board as members. Issues such as RICPG and Committees and Task Force meeting times, the length of the meetings, and methods of participation make it difficult to address this issue.

Solution-oriented discussions have included: collaborating with the Youth Task Force for creative insight, creating a capacity-building training on this issue through the REACH/Capacity Building Committee, and creating incentives and/or a separate RICPG youth advisory group with representation at general RICPG meetings.

MSM

While RICPG has MSM representation, it does not currently have any MSM/IDU members - and the MSM Task Force membership is low. The Task Force has done some recruitment of their own and identified two potential members.

Faith-Based

Another issue being discussed is the possibility of recruiting members from faith-based organizations. Committee members discussed possible obstacles in faith-based recruitment, including how to benefit from the insights of a faith-based member without alienating members who practice high-risk behaviors and are not part of a faith community. Broad-based geographic recruitment has also been discussed, but will not be the focus while the group remains in low-membership status. Geographic recruitment will be considered in the near future.

Efficiency

Efforts to improve the efficiency and effectiveness of RICPG documentation processes include:

- **Revising forms—**the nomination/application form has had minor content and format changes and can now be completed electronically. (It will continue to be mailed in with original signature.)
- **Revising Orientation Manual and Procedure—**Discussions are underway with the group's new facilitator to enhance the Orientation Manual with an orientation video.
- **Recommending changes to the RICPG Charter (for consideration by the full membership)—**The specific work on the charter involves clarifying wording around the process for public comment, voting on new members, removing co-chairs, conflict management, etc. In addition, the Committee has worked on clarifying maximum and minimum membership.

The Community Empowerment Committee recently accepted the resignation of a community co-chair due to workload and other obligations. In addition, the Committee received one member resignation this year due to health concerns.

This Committee is highly motivated and productive, meeting twice a week and more frequently when needed. However, the Committee needs new members to assist in its charge. It is expected that when the RICPG as a whole reaches full membership capacity, this issue will be addressed.

Strategic Planning Committee

The Strategic Planning Committee is responsible for Goal 2, Objectives D, E, and F, and Attributes 19–48. The Committee maintains the attributes throughout the year, incorporates the attributes into written RICPG documents, and works toward accomplishing the attributes according to its preset timeline.

Duties of the Strategic Planning Committee include:

- Monitoring of the development of the resource inventory of HIV prevention services.
- Review of current epidemiologic profile and determination of trends in incidence and prevalence.
- Review of "best practice" HIV prevention interventions.
- Categorization of interventions by type of intervention and stage of change.
- Development of a prioritization plan for target populations and interventions.
- Facilitation of RICPG discussions related to unmet needs, priority populations and priority interventions.
- Completion of a gaps analysis for three of the five priority populations.
- Evaluation of the community planning process and capacity building activities with John Snow, Inc., an agency contracted for evaluation by HEALTH-RI.
- Development and execution of at least two community forums designed to gather input from specific populations.
- The ongoing process of identifying unmet and partially met needs.

REACH/Capacity Building Committee

The REACH/Capacity Building Committee is responsible for Goal 3, Objectives G and H, and Attributes 49–52. The Committee oversees programs of the RICPG and advises Project REACH, the capacity-building program for HIV prevention of the HEALTH-RI Office of HIV and AIDS.

In January 2004, a new contract to operate Project REACH was awarded to the Drug and Alcohol Treatment Association of Rhode Island (DATA). Following the award of this contract, a program coordinator was hired for Project REACH in February 2004. In May 2004, the program coordinator resigned and an interim coordinator was appointed. The new program coordinator began on August 30, 2004.

During 2004, the Committee advised Project REACH in the development of a comprehensive set of capacity building activities to be conducted from August to December

2004. Between January and July 2004, the Committee and REACH staff met four times. In addition, REACH staff attended all scheduled RICPG meetings, meetings with the RICPG co-chairs and consultants, and meetings with HEALTH-RI staff.

In cooperation with HEALTH-RI, Project REACH has begun the preliminary work to establish a certification process for HIV prevention workers, including the drafting of core knowledge and skills for prevention workers.

Duties of the REACH/Capacity Building Committee include:

- Advising and providing input and guidance to Project REACH.
- Participating in the identification of topics for the Fall REACH workshop series.
- Responding to ongoing requests for technical support by prevention providers.
- Assessing the capacity building needs of HIV prevention professionals.
- Identifying additional capacity building resources.
- Performing outcome monitoring and impact evaluation.

The following calendar was created for the RICPG members outlining the activities of the major community planning task for 2005.

2005 Rhode Island Community Planning Yearly Calendar					
January 2005	**Febuary 2005**	**March 2005**	**April 2005**	**May 2005**	**June 2005**
Theme: Recognition of Unsung Heroes **Unveiling of the 2005 Plan** **RICPG Annual Conference – an opportunity to review the past year and transitioning into the new year**	**Theme: Setting the Agenda for the Year** **Strategic Planning:** Review the goals, objectives and attributes in the guidance and plan. **TASK FORCE:** Work through workbooks and establish logic model **Empowerment** New Community Co-chair Orientation New Member orientation Continue to update charter **REACH Steering Committee** Develop capacity building training and activities for summer/fall catalog ; review JSI report on the RICPG survey to determine the future RICPG capacity building needs; develop certification process **RICPG Consultant Team** Consultants Strategy Planning Meeting JSI-RICPG Survey results	**Theme: Catching Up** Focus on Committee and Task Force Reports and Status. An opportunity for recommendations and guidance to task force members. **Strategic Planning:** Continue to support the Task Forces in the use of the workbook and determine epi support needs; work with HEALTH-RI to finalize the resource inventory. **TASK FORCE:** Prepare presentation to the RICPG. **Empowerment** New Community Co-chair Orientation New Member orientation Prepare charter updates for the RICPG vote **REACH Steering Committee** Develop capacity building training and activities for summer/fall catalog:; JSI report to the RICPG identifying their capacity building needs. **RICPG Consultant Team** Consultants Strategy Planning Meeting	**Theme: Putting It all Together** Day long retreat style meeting/training event **Skill Building/Tool Box** The epi profile-understanding prevalence, incidence etc. **Skill Building/Tool Box** Gaps Analysis **RICPG Capacity Building** Community Service Assessment **Empowerment** Finalize the Charter **REACH Steering Committee** Develop capacity building training and activities for summer/fall catalog; new draft catalog is presented. **RICPG Consultant Team** Plan the retreat building activities JSI Update on Vendor Evaluation REACH Update on capacity building	**Theme: Putting It all Together** Finalizing the updates for the Plan Update in 2006. **Strategic Planning:** Guide members with recommendations to the task force members; **Empowerment** Decisions about the annual event, RRR, and awards. New Member orientation **REACH Steering Committee** Capacity building training and activities for summer/fall catalog is finalized and published **RICPG Consultant Team** Consultants Strategy Planning Meeting Clarendon Communication Plan Update	**Theme: Draft of the Plan Update** **Strategic Planning:** Continue to guide members with recommendations to the task force members **TASK FORCE:** Work through workbooks and continue assessments **Empowerment** Continue to plan the annual event, Red Ribbon Rally, and awards. New Member orientation **REACH Steering Committee** Capacity building training and activities for summer/fall training begins enrollment for July **RICPG Consultant Team** Consultants Strategy Planning Meeting Draft of the Plan Update is prepared.

2005 Rhode Island Community Planning Yearly Calendar					
July 2005	**August 2005**	**September 2005**	**October 2005**	**November 2005**	**December 2005**
Theme: Plan Update is Complete Final version of Plan update includes the activities of the RICPG in 2004-5. **Strategic Planning:** Continue to guide members with recommendations to the task force members; reports on the gaps analysis and resource inventory **TASK FORCE:** Work through workbooks and continue assessments **Empowerment** Continue to plan the annual event, RRR, and awards. New Member orientation **REACH Steering Committee** Capacity building training and activities for summer/fall catalog training implemented; certification process is under way **RICPG Consultant Team** Consultants Strategy Planning Meeting Draft of the Plan Update is completed	**Theme: Mid year Assessment** Assessment of the RICPG activities so far. **Strategic Planning:** Guide task force with the prepare of second presentation of activities to the RICPG **TASK FORCE:** Prepare presentation to the RICPG. **Empowerment** Continue to plan the annual event, RRR, and awards. New Member orientation Suggest charter updates to the RICPG to prepared **REACH Steering Committee** Capacity building training and activities for summer/fall catalog training implemented; certification process continues **RICPG Consultant Team** Consultants Strategy Planning Meeting	**Theme: Final Assessment** The RICPG considers future activities with the task force assessment **Strategic Planning:** Recommendations to the RICPG based on the task force activities; reports on the gaps analysis and resource inventory **TASK FORCE:** Presentation to the RICPG. **Empowerment** New Community Co-chair nominations gathered Continue to plan the annual event, RRR, and awards **REACH Steering Committee** Capacity building training and activities for summer/fall catalog training implemented; certification process continues; next catalog is planned. **RICPG Consultant Team** JSI prepared the RICPG survey; Clarendon provides update on the RRR and annual conference marketing plan	**Theme: Preparing for the Red Ribbon/Annual Event** The RICPG finalize decisions about the marketing of the RICPG, annual conference theme and RRR. **Empowerment** New Community Co-chair nominations gathered New Member orientation Continue to plan the annual event, RRR, and awards **REACH Steering Committee** Capacity building training and activities for summer/fall catalog implemented; certification process continues; winter/spring catalog for 2006 is published **RICPG Consultant Team** Consultants Strategy Planning Meeting JSI implements the RICPG survey Clarendon presents RRR and annual conference updates to RICPG	**Theme: Preparing for the New Year** The election of new community co-chair **Empowerment** New Community Co-chair nominations gathered Continue to plan the annual event, RRR, and awards **REACH Steering Committee** Capacity building training and activities for summer/fall completed; enrollment for winter/ spring catalog of workshops begins. **RICPG Consultant Team** Consultants Strategy Planning Meeting	**Reflections/Celebrations** **December 1, 2005** **Red Ribbon Rally** **State House**

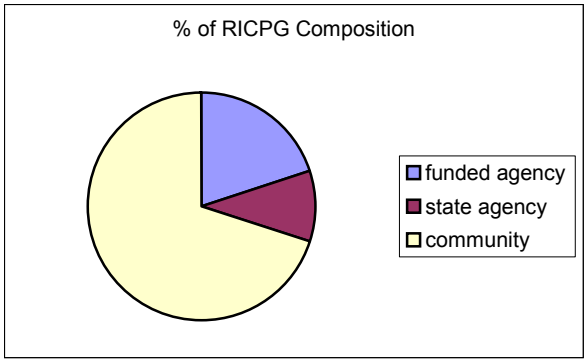
Goal One

Goal One: Community planning supports broad-based community participation in HIV prevention planning and evaluates the progress of this by increasing RICPG member perceptions across the five-year grant process, as well as monitoring intermediate outcomes of the process associated with this objective.

- Indicator E.1: Proportion of population most at risk, as documented in the epidemiologic profile, that has at least one RICPG member that reflects the perspective of each population.

Objective A: Implement an open recruitment process (outreach, nominations, and selection) for RICPG membership.

Each year, the Community Empowerment Committee reviews the process of bringing new members into the fold. This year, the committee again revised the nomination form (Appendix B: Member Nomination Form) and created more objective indicators for eligibility. The group also specified membership composition percentages for individuals from funded agencies, state agencies, and the community at large (see the chart below). The recruitment process is widespread and inclusive of the entire state and is generally achieved through extensive and focused outreach, primarily through advertisement in statewide newspapers, ethnic papers, and other broad channels of distribution (e.g., community-based agencies post recruitment flyers). This year, recruitment also included phone calls to key referral sources.



In addition, this Committee reviews the status of existing members and is responsible for filling vacancies that occur during the year by recording and monitoring terms. An important component of this recruitment process is ensuring that priority populations continue to be adequately represented in the membership of the RICPG. This Committee is also responsible for orienting new members and assisting them in assimilating into the existing group.

Member Retention Plan

Member retention provides stability to the RICPG and continuity for the planning process.

The retention plan for RICPG involves the following steps:

- Motivation: the committee creates a motivating environment and targets retention strategies for new and experienced members.
- Development: the committee creates strategies for orientation, training, coaching, capacity building and networking opportunities.
- Management of volunteer resources: the committee identifies key competencies for members, works with challenging members, and encourages members to step down when necessary.
- Member recognition.

Motivation

Motivational efforts include the following activities:

- The RICPG facilitator has restructured the meeting agenda to include a warm-up activity at the beginning of each meeting and a closure activity when the meeting ends. The purpose of the meeting structure is to offer an opportunity for the membership to personally connect with each other and to the mission and purpose of the RICPG.

- The RICPG's new social marketing consultant, the Clarendon Group, has created polished materials to help showcase the work of the group, including a new logo (voted on by the membership), Executive Summary of the 2004 Plan, brochures, buttons, new stationery, and a pending new website are strategies to help connect the members with their work. The future plan is to have the members' pictures posted on the web, further associating the people with the work.
- The RICPG leadership team has developed workbooks to help clarify and guide the work of the group, and they also assist in motivating the membership to connect the goals with the planning process.
- RICPG members now provide frequent and immediate feedback on meeting objectives which serves to motivate members by acknowledging the value of their input.

Development

The Empowerment Committee, with support from the facilitator, is working to change forms, including nomination forms, to be more user-friendly. The development of the Task Force workbooks have helped by offering consistency in how information is collected in the task forces and avoids duplication of effort. Also, the workbooks help to break the work down into manageable steps.

The REACH Capacity Building Subcommittee has involved the membership in determining their training needs. The Subcommittee has developed a catalog of trainings to respond to these identified needs. Furthermore, the general planning meetings of the subcommittee have scheduled breaks for participants to maximize the networking opportunities that come naturally with this work.

Management

- The RICPG web site offers a calendar to assist members in accessing information on General Planning, Committee and Task Force meetings.
- Regular communication with the co-chairs and membership is facilitated through mail, e-mail, phone, and catching up at meetings.

- Input from the membership is requested through meeting evaluations and the JSI evaluation survey.
- An outside consultant has been used to assist in conflict management.
- The Co-Chairs manage the general planning meetings and the facilitator serves to assure that the objectives are met. In Committees and Task Forces meetings, the chairs manage the meetings and the Facilitator supports the Chairs as needed. Minutes are taken in all meetings to document the work.

Recognition

Personal phone calls and e-mails are used to acknowledge the work of the membership and provide consistency in communication, which in turn serves to support the momentum and validate member contributions.

Web site postings of member accomplishments and news articles are planned to assist in recognizing the work of the membership. Options of posting member pictures on the web, informing members of the impact of the work, and requesting input in areas of expertise are all strategies for recognition that are now and will continue to be part of the retention process. The Empowerment Committee will continually investigate options and opportunities to enhance the recognition efforts.

The committee believes that the annual review of this process by a dedicated sub-committee ensures the long-term maintenance of the open recruitment and retention process.

The long-term maintenance of Objective A is outlined in the following matrix.

Goal One: Community planning supports broad-based community participation in HIV prevention planning				
Objective A In year 2005	**Activities**	**Outputs**	**Immediate Outcomes (2005)**	**Intermediate Outcomes (5 year) (2009)**
Implement an open recruitment process (outreach, nominations, and selection) for RICPG membership.	• Empowerment Committee reviews and alters recruitment/ selection process and success is defined by maintaining at-risk population representation on RICPG • Vacancies are quickly filled within one month to maintain representation • Special recruitment • Revised nomination/ procedures/ forms distributed • Ads in newspaper • Personal Call Schedule • Distribute a RICPG brochure as a public relations/ recruitment tool • Address any gaps in membership, the nomination process, interview process and selection	Attribute 1 (Nominations): Presence of written procedures for nominations to the RICPG. Attribute 2 (Nominations): Evidence that written procedures (above) were used for nominations to the RICPG. Attribute 3 (Nominations): Evidence that a nominations committee has been established. Attribute 4 (Nominations): Evidence that nominations targeted membership gaps as identified by the RICPG. Attribute 5 (Selection): Evidence that membership decisions involve more than the health department staff. Attribute 6 (Selection): Written documentation of the process for selection of RICPG members. Attribute 7 (Selection): Evidence that the process (above) was used in selection of RICPG members.	• Enhance Attributes 1-7 by January 2005 • Maintain attributes throughout the year • Attributes 1-7 are incorporated and updated into written RICPG documents • As an ongoing process • 100% attainment of Attributes 1-7	The RICPG continues to represent the communities most affected by HIV/AIDS and each corresponding objective is reviewed by the RICPG and maintained. 100% of the attributes 1-18 are in place.

Objective B: Ensure that the RICPG's membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in Rhode Island, and include key professionals representative of key government and non-governmental agencies.

The RICPG's Community Empowerment Committee is responsible for the overall member recruitment and retention. A membership grid is consulted each time someone leaves the group and a meeting of the Community Empowerment Committee is called by the Chair. The membership grid (Appendix C: Membership Grid) reveals a deliberate mix of governmental and non-governmental agency representatives. The Community Empowerment Committee specified in its most recent revision of the nomination form (Appendix B: Member Nomination Form) the allowable percentages of government agency representation, representatives from community based and funded organizations (non-government agencies), and community representatives. The Committee's intent was to create an equitable mix of members so as not to "tip" the scales with too many non-community representatives. In addition, the RICPG is dedicated to involving key consultants with professional expertise into the fold of the planning process. As a result, a consultant list (non-members, but active participants in the process) is attached to the membership grid. The distinction of these individuals as consultants allows the RICPG to access their expertise at any time and ensures a broader base of input.

Youth Involvement

One of the RICPG's most persistent challenges is to involve youth in a meaningful way in its membership and planning process. To address this challenge, at least two persons between the ages of 16 and 24 have been appointed to the RICPG.

People Living with HIV/AIDS

To enhance communications with PLWHA, who are not RICPG members, the Office of HIV & AIDS will continue to present to the RICPG and the Provision of Care Committee an update on care issues (including Ryan White I and II). In addition, the Bridge Committee will commence their work in 2005, formally linking prevention with provision of care. This

group is integral to both the RICPG and the Provision of Care Committee (POC). It will be made up of providers from prevention and care. The group will meet at least quarterly to determine issues to be presented to the RICPG and the POC.

Outside Input

In 2003, focus groups representative of each priority population were conducted to measure perceptions of the appropriateness, clarity, and accuracy of the RICPG's goals and objectives specific to each population; service needs and gaps for each population; and overall plan to address each population's needs. The focus groups were facilitated and the recommended actions were documented.

Linkages with Other Groups

In 2004–05, RICPG members will participate in other groups whose missions dovetail with HIV prevention, thus forging linkages among agendas. These groups include the ENCORE Steering Committee, which oversees the state's needle exchange program; HIV Minority Community Partnership; Partners in Care, which focuses on CTR issues; and the Materials Review Committee of the State Departments of Health and Education, which reviews, approves, and orders HIV prevention materials.

In addition, three members of the Coalition of AIDS Education Providers (comprised of all providers funded by the HEALTH-RI Office of HIV and AIDS) are RICPG members, and the REACH facilitator attends the Coalition's meetings.

In 2002, the HIV Advisory Committee, which had been the group that considered treatment issues, merged with the HIV Provision of Care Committee, through which the allocation of Ryan White funds took place. A member of the RICPG is a member of this committee and the HEALTH-RI consultant to the RICPG staffs the HIV Provision of Care Committee.

Community Forum

Each December, the Community Empowerment Committee hosts a Community Forum to raise awareness about the efforts of the RICPG, introduce the public to the Community Plan

for HIV Prevention, and obtain additional input from outside the group membership. In 2003, about 225 community participants attended this event.

At this event, the RICPG also honors individuals, groups, and organizations that have made a significant contribution to HIV prevention in Rhode Island. Increasing in attendance each year, the event has become an invaluable opportunity to unveil the Plan to the public and to acknowledge the good work of the RICPG. It also serves as an example of the RICPG's open, participatory philosophy of planning; each year the community is asked to comment on the Plan and to offer suggestions for improvement.

With the assistance of the social marketing consultant, Clarendon Group, the RICPG is reconsidering the structure and purpose of this event. Along with the Red Ribbon Rally (a World AIDS Day event jointly sponsored by HEALTH-RI and the RICPG for the first time in 2003), the RICPG sought the expertise of Clarendon Group to improve the impact on the community.

The long-term maintenance of this objective is outlined in the following matrix.

Goal One: Community planning supports broad-based community participation in HIV prevention planning				
Objective B In year 2005	**Activities**	**Outputs**	**Immediate Outcomes (2005)**	**Intermediate Outcomes (5 year) (2009)**
Ensure that RICPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in Rhode Island, and include key professionals representative of key government and non-governmental agencies.	• Empowerment Committee reviews process monthly • Membership Grid is maintained as part of recruitment and selection of new members • Expert Consultant list maintained • 2004 recruitment completed and end result represents diversity of populations • Invite inter-state agencies to a "RICPG day" to promote benefits of RICPG involvement • Maintain JSI Evaluation survey each October • Conduct Membership (Feedback Survey) after each RICPG meeting	**Attribute 8 (Representation):** RICPG includes: (a) members who represent populations most at risk for HIV infection as reflected in the current and projected epidemic, as documented in the prior year's epidemiologic profile, and (b) persons living with HIV/AIDS **Attribute 9 (Representation):** RICPG membership includes members who represent the affected community in terms of race/ethnicity, gender/gender identity, sexual orientation, and geographic distribution **Attribute 10 (Representation):** RICPG membership includes, or has access to, professional expertise in behavioral/social science, epidemiology, evaluation, and service provision **Attribute 11 (Representation):** RICPG membership includes, or has access to, key government agencies, including: health department HIV/AIDS program and the state/local health department STD program staff **Attribute 12 (Representation):** RICPG membership includes, or has access to, key governmental and non-governmental agencies with expertise in factors and issues relative to HIV prevention	• Enhance Attributes 8-12 by January 2006 • Maintain attributes throughout the year • Attributes 8-12 are incorporated into written RICPG documents by 12/04 • 100% attainment of Attributes 8-12	The RICPG continues to represent the communities most affected by HIV/AIDS and each corresponding objective is reviewed by the RICPG and maintained. 100% of the attributes 1-18 are in place.

Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.

This objective is intrinsic to the RICPG process. Since May 2004, HEALTH-RI has contracted with Uptyme to facilitate the process of community planning. The key role of the consultant is to ensure parity, representation and inclusion at each meeting. With the facilitation of the consultant, the RICPG was able to do the following in a few short months:

- produce RICPG pins and brochures for recruitment.
- establish a website with meetings, charter, and other RICPG information.
- sponsor Project REACH trainings with a six month catalog based on the RICPG input.
- prepare members to review the 5 year plan in a timely fashion.
- recruit two new members and have two other potential members begin the recruitment process. One is a youth leader from the Narragansett Reservation who teaches AIDS curriculum in response to a recent outbreak on the Reservation.
- develop a new youth recruitment strategy from the substance abuse field and schools to support the youth task force.
- draft a task force workbook guide and focus task force activities. The task force efforts are a major component to the Community Service Assessment section in the plan.
- task the Empowerment Committee to make much-needed changes to the RICPG charter.
- redesign and update the orientation training curriculum. (A new video is being reviewed to be included in the training.)
- plan to integrate local process and outcome data into decision making and priority setting.
- guide consultants' with assisting the RICPG to process and plan (e.g. Clarendon, JSI, DATA).
- use the yearly member survey to improve the function of the group.
- demonstrate the RICPG's capacity to deal with discord and conflict in a positive manner.

Conflict Resolution

Conflict is an inevitable part of the RICPG process. Where diverse cultures are joined together, conflict is expected. This year, the RICPG worked to minimize conflicts that impede progress by revising the group's ground rules; in addition, the Facilitator reviewed the ground rules and provided them in printed format in member packets at all meetings. The Facilitator offered reminders of the role of conflict in helping or hindering the group's progress. Team-building exercises have been made a part of the opening at every meeting with the goal of building trust and connection. In addition, closing meeting objectives are reviewed for communication and goal clarity.

Although these strategies minimized conflict, an outside facilitator was also used to assist the group through a conflict resolution process. Afterward, proactive steps have been taken to build the RICPG capacity to effectively manage conflicts internally. The Empowerment Committee is currently developing a conflict management policy, Conflict management training as part of the REACH Capacity building efforts is currently being considered. The facilitator will continue to monitor the communication process and provide regular feedback to the group.

The Empowerment Committee has taken on the responsibility of mediating some relationship conflicts whenever they may be needed. Peer Mediation is new to this group. Future plans will include the CDC guides as base for formalizing conflict management policy and protocol.

The following matrix outlines the long-term strategy to maintain parity and inclusion:

Goal One: Community planning supports broad-based community participation in HIV prevention planning				
Objective C In year 2005	**Activities**	**Outputs**	**Immediate Outcomes (2005)**	**Intermediate Outcomes (5 year) (2009)**
Foster a community planning process that encourages inclusion and parity among community planning members.	• Continue to administer membership assessment after each meeting ▪ Improve baseline of member perceptions around PIR ▪ Tabulated assessments pertaining to inclusion/parity with timely feedback to RICPG each quarter • Community Empowerment Committee charged with monitoring this objective and regularly assesses PIR • Maintain JSI Evaluation survey each October • Conduct Membership (Feedback Survey) After each RICPG meeting	**Attribute 13 (Inclusion):** Evidence that the RICPG convened ad hoc committees, panels, and/or focus groups to gain input from representatives of marginalized groups, who would be hard to recruit and/or retain as RICPG members,. **Attribute 14 (Inclusion):** Evidence that efforts were undertaken to accommodate or facilitate members who face challenging barriers (e.g., health care or economic needs) to their continued participation in the RICPG. **Attribute 15 (Inclusion):** Evidence of a clear decision-making process, including conflict of interest rules. **Attribute 16 (Inclusion):** Evidence of an orientation, mentoring or training process for new RICPG members. **Attribute 17 (Inclusion):** Evidence that RICPG meetings are open to the public and allow time for public comment. **Attribute 18 (Parity):** Evidence of ongoing training process for all RICPG members.	• Establish Attributes 13-18 by January 2006 • Maintain attributes throughout he year • Attributes 13-18 are incorporated into written RICPG documents by 12/05 • 100% attainment of Attributes 13-18 by 12/05	The RICPG continues to represent the communities most affected by HIV/AIDS and each corresponding objective is reviewed by the RICPG and maintained. 100% of the attributes 1-18 are in place.

Goal Two

Goal Two: The Rhode Island Community Planning Group identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population).

- Indicator E.2: Proportion of key attributes of an HIV prevention community process that RICPG membership agrees have been addressed.

The work of the RICPG is driven by the core objectives set forth by the CDC. The revised guidance has been shared with the RICPG, and members are aware that the components of community planning have been revised and that the group must continue to address the new guidelines in this phase of the process.

The RICPG has been notified that the CDC expects HIV prevention community planning to improve HIV prevention programs by strengthening the (1) scientific basis, (2) community relevance, and (3) population-or-risk-based focus of HIV prevention interventions in each project area. The overall goals in this revised guidance have also been discussed with the RICPG, and they reflect the philosophical intent of this local planning body. (Appendix D: Getting Up to Date with the RICPG)

<u>Objective D: Carry out a logical, evidence-based process to determine the highest priority populations' specific prevention needs as well as priority interventions for the target populations in Rhode Island.</u>

HEALTH-RI proposed and implemented an intensive training program for all RICPG members related to prioritization of populations and interventions. In the Spring of 2003, the prioritization plan was formulated with the co-chairs, and key staff from HEALTH-RI. The plan was to reorganize the process by which RICPG prioritized populations and create a more objective process that would be viewed as such by the group. As a result, a series of small workshops were scheduled. Each RICPG member was asked to sign up for one of three identical sessions. During the workshops, HEALTH-RI went through a customized workbook

and assisted members with completing the individual score sheets. This procedure for setting priorities was selected to give members time to review the data and materials and formulate questions.

Approximately 95% of the RICPG attended one of these workshops. The thought was to prepare the group in small sessions for the "new, improved" prioritization exercise. The small groups were facilitated by HEALTH-RI and RICPG members who had been briefed as to the components of the new exercise. Each participant received a workbook and was asked to do a homework assignment before the actual prioritization took place in a full member RICPG meeting.

At the May 2003 meeting, RICPG members completed the population priority process that included an informational session on the draft guidelines for community planning recently issued by the Centers for Disease Control and Prevention. Members were given a packet with a copy of the draft guidance and it was discussed with an overhead presentation. The information was based on the workshop on Community Planning presented at the AIDS Summit in New York in April. Members were re-introduced to their role in priority setting and the priority setting workbook developed for this process was reviewed.

The 2003 prioritization exercise was brought forth to the 2004 planning year and the RICPG agreed that the process for prioritizing in 2003 was a good one. They felt, however, that it was important to review the HIV/AIDS reporting data sets, to be certain that priorities did not change since 2003. In fact, there were no significant changes. That is not to say the RICPG was completely satisfied with using HIV/AIDS data to determine priorities. Workbooks allowed us to bring another level of thinking to how we prioritize, and how the group addresses the associated components of each target population.

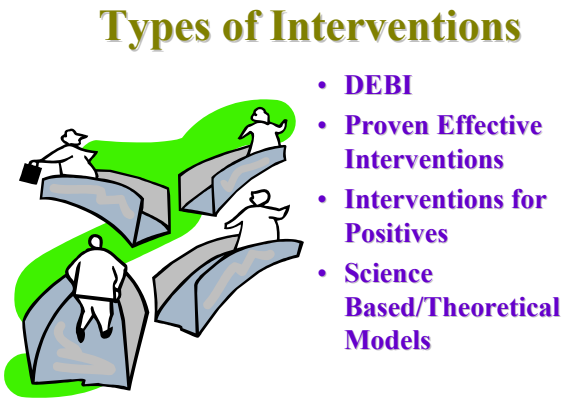
As indicated in the Task Force workbook, an entire section is devoted to prioritization. This section illustrates that the following areas must be considered along with the HIV/AIDS incidence/prevalence data:

- Estimated Size of Target Population

- Barriers to Prevention
- Risk Behaviors/Conditions
- Risk Rating

As a result, each target population will have a priority "wheel" that the RICPG will use as the basis for planning.

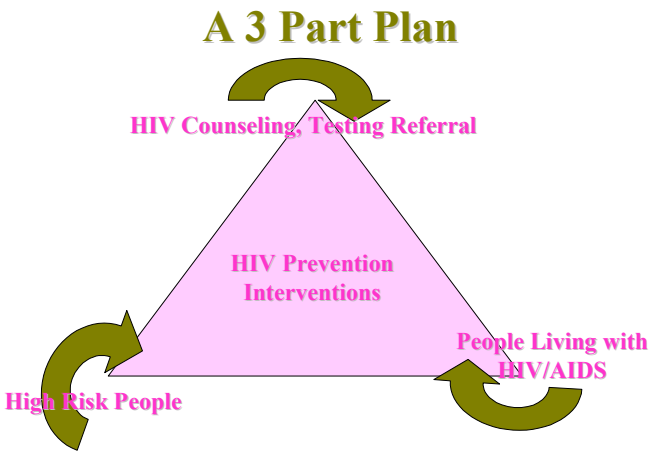
The text below represents how the RICPG approaches the notion of best practices.



The RICPG takes into consideration interventions for high-risk populations and people with HIV/AIDS. There are three general possibilities:

1. Interventions that have already been evaluated with outcome evaluations and have been proven to be effective with high-risk populations. These interventions are known as DEBI and REP (Replicating Effective Programs)
2. Programs that have been proven effective with people living with HIV/AIDS.
3. Interventions sponsored by local programs that have not been proven effective. The program would need to be based on an adaptation of a DEBI or has a theoretical model. This type of program would need to have an outcome evaluation (not just outcome monitoring) in place in order to be funded. The agency would have to prove that they are implementing an effective program.

CDC's HIV Prevention Strategy has three parts:



1. HIV Counseling and testing, especially rapid testing interventions, in proven effective settings.
2. Prevention with persons at high risk for HIV (as defined in the next slide).
3. Prevention for people living with HIV & AIDS.

There are proven, effective programs for each of these three strategies.

The CTR interventions are described in detail in the "Advancing HIV Prevention: Interim Technical Guidance for Selected Interventions". This has been handed out at RICPG meetings on several occasions and can be downloaded from the CDC web site: http://www.cdc.gov/hiv/partners/ahp.htm#journal

Who is High Risk for HIV?

Within the past 6 months have:

- **Unprotected sex with a person living with HIV**
- **Unprotected sex in exchange for money or drugs**
- **Multiple (greater than five) or anonymous unprotected sex or needle-sharing partners**

OR

- **Diagnosed with a sexually transmitted disease**

This group includes those people who, within the past six months, have:

- Had unprotected sex with a person living with HIV.
- Had unprotected sex in exchange for money or drugs.
- Had multiple (greater than five) or anonymous unprotected sex or needle-sharing partners
- Been diagnosed with a sexually transmitted disease.

Priority for Prevention Case Management (PCM) services should be given to HIV seropositive persons.

HIV seronegative persons or those of unknown HIV serostatus may be appropriate for PCM **if**:

- They meet the criteria of an individual at very high risk for HIV infection **and**
- They are experiencing competing issues that affect their ability to address HIV prevention needs.

Prevention for High Risk People

- **DEBI**
- **Other Proven Effective Interventions**
- **Local Programs**

Prevention programs for people at high-risk may come from three types of interventions:

1. The DEBI – a series of interventions that CDC is recommending because they are proven effective and CDC has trainings and materials (curriculum) that agencies can access without cost. There are DEBIs for high risk and PLWHA.

2. Interventions proven effective, including the DEBIs, are listed in the "Compendium of HIV Prevention Interventions with Evidence of Effectiveness". The compendium is available at the CDC web site: www.cdc.gov/hiv/partners/ahp.htm#journal.

3. Local programs can use a theoretical model such as peer counseling, natural helper, social development model, stages of change, etc. These programs must prove they are effective by doing outcome evaluation, not just outcome monitoring.

What's a DEBI ? A Winner

- **A proven effective program for high risk and PLWHA.**
- **Group and community based interventions.**

The **Diffusion of Effective Behavioral Interventions project (DEBI)** is a national-level strategy to provide high quality training and on-going technical assistance on selected evidence-based HIV/STD prevention interventions to state and community HIV/STD program staff. DEBIs have an emphasis on group level and community level interventions.

The interventions have been proven effective through research studies that showed positive behavioral (e.g., use of condoms; reduction in number of partners) and/or health outcomes (e.g., reduction in the number of new STD infections). Studies employed rigorous research

designs, with both intervention and control groups, so that the positive outcomes could be attributed to the interventions. With input from the researchers, the materials necessary to implement the interventions have been packaged into user-friendly kits. With the appropriate training and intervention package, service providers can increase their opportunities to conduct effective HIV/STD prevention programs in their communities.

Why Community and Group-Level Interventions?

Community- and group-level interventions, compared to individual-level, have the potential to reach large numbers of the population and reach individuals at high risk who might not voluntarily seek prevention information or services. They are also more cost-effective.

HIV Prevention Interventions

The interventions in the Compendium have been identified by CDC's HIV/AIDS Prevention Research Synthesis Project (PRS) as having used rigorous study methods and demonstrated evidence of effectiveness in reducing sex- and drug-related risk behaviors and/or improving health outcomes.

Request a Regional Training

Agencies that are interested in and have the capacity to implement the HIV prevention interventions can schedule a training in their area on the intervention of their choice. Rhode Island could offer this regional training through REACH. For more information, visit: www.effectiveinterventions.org.

Diffusion of Effective Behavioral Interventions Project (DEBI)

Street Smart	Voices/Voces Project Respect
Popular Opinion Leader (POL)	Mpowerment
Real AIDS Prevention Project (RAPP)	Safety Counts
SISTA	Community Promise

Popular Opinion Leader: This community-level intervention involves identifying, enlisting, and training key opinion leaders to encourage safer sexual norms and behaviors in their social networks through risk-reduction conversations.

Promise: This community-level intervention is based on several behavior change theories. A community assessment process is conducted, peer advocates are recruited and trained from the target population, role model stories are written from interviews with the target population, and these stories are distributed along with other risk reduction materials to target audiences to help people move toward safer sex or risk reduction practices. The intervention can be adapted for various population groups (IDUs, MSM, sex workers, Native Americans, and youth at high risk).

Voices/Voces: A group-level, single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Participants, grouped by gender and ethnicity, view an English or Spanish video on HIV risk behaviors and condom use and take part in a facilitated discussion.

S*ISTA*: This group-level, gender- and culturally- relevant intervention is designed to increase condom use among African American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk

reduction behaviors and decision making. The intervention is based on Social Learning theory as well as the theory of Gender and Power.

Street Smart: A multi-session, skills-building program to help runaway and homeless youth practice safer sexual behaviors and reduce substance use. Sessions address improving youths' social skills, assertiveness and coping mechanisms using exercises on problem solving, identifying triggers, and reducing harmful behaviors. Agency staff also provides individual counseling and trips to community health care providers.

Safety Counts: Safety Counts is an HIV prevention intervention for active injection drug and crack cocaine users aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings. This intervention works well with CDC's Advancing HIV Prevention initiative as it strongly encourages HIV testing as a precursor to program enrollment, clients can be recruited from testing programs, and sessions include a discussion of the importance of testing to the client. The intervention addresses the needs of both HIV-negative and HIV positive clients.

Mpowerment: This community-level intervention for young men who have sex with men uses a combination of informal and formal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages.

Real AIDS Prevention Project (RAPP): A community mobilization program, designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use. This intervention relies on peer-led activities, including: outreach/one-on-one brief conversations with brochures, referrals, and condom distribution; small group safer sex discussions and presentations. There is also peer interaction with community businesses, who participate in media campaigns with distribution of role model stories and prevention and health information newsletters and brochures. RAPP is based on the transtheoretical model of behavior change.

Following are two different types of matrices, one describing the goals and objectives over time, and the other the status (progress) of the specific attributes for each area. (See next page.)

Objective D In year 2005	Activities	Outputs	Immediate Outcomes (2005)	Intermediate Outcomes (5 year) (2009)
Carry out a logical, evidence-based process to determine the highest priority populations' specific prevention needs, as well as priority interventions for the target populations in Rhode Island.	• RICPG facilitator uses the survey findings for future leadership activities and to adjust key attributes goals and maintain them. • Conduct trainings using RICPG prioritization workbook for RICPG/HEALTH-RI Staff/Consultants to increase knowledge of participants regarding key attributes19-36 and maintenance of these. • Complete and annually review a priority "wheel" for each target group to augment the formal prioritization exercise.	**Attribute 19 (Epidemiologic Profile):** The epidemiologic profile provides information about defined populations at high risk for HIV infection for the RICPG to consider in the prioritization process. **Attribute 20 (Epidemiologic Profile):** Strengths and limitations of data sources used in the epidemiologic profile are described (general issues and jurisdiction-specific issues). **Attribute 21 (Epidemiologic Profile):** Data gaps are explicitly identified in the epidemiologic profile. **Attribute 22 (Epidemiologic Profile):** The epidemiologic profile contains a narrative interpretation of data presented. **Attribute 23 (Epidemiologic Profile):** Evidence that the epidemiologic profile was presented to the RICPG members prior to the prioritization process. **Attribute 24 (Community Services Assessment):** The Community Services Assessment (CSA) focuses on one or more high priority populations (i.e., substantially contributing to new HIV infections in a jurisdiction) identified in the epidemiologic profile. **Attribute 25 (Community Services Assessment):** Data are gathered that define populations' needs in terms of knowledge, skills, attitudes, and norms. **Attribute 26 (Community Services Assessment):** Data are gathered that define populations' needs in terms of access to services. **Attribute 27 (Community Services Assessment):** The CSA details the target populations being served. **Attribute 28 (Community Services Assessment):** The CSA details the interventions provided to each target population. **Attribute 29 (Community Services Assessment):** The CSA describes the geographic coverage of interventions or programs. **Attribute 30 (Community Services Assessment):** The CSA was utilized in demonstrating linkages between the application and funded interventions. **Attribute 31 (Community Services Assessment):** Evidence that prior to the prioritization process, the RICPG was provided with a summary of the CSA. **Attribute 32 (Gap Analysis):** The gap analysis includes data from the epidemiologic profile and CSA. **Attribute 33 (Gap Analysis):** A gap analysis specifically identifies both met and unmet needs. **Attribute 34 (Gap Analysis):** The gap analysis identifies the portion of needs being met with CDC funds. **Attribute 35 (Gap Analysis):** Evidence that prior to the prioritization process, the RICPG was provided with a summary of the gap analysis findings. **Attribute 36 (Gap Analysis):** The gap analysis was utilized by the RICPG in demonstrating linkages between the application and funded interventions.	• Maintain attributes throughout the year • Attributes 19-36 are incorporated into written RICPG documents • 100% attainment of Attributes 19-36 annually.	The RICPG continues to identify priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in Rhode Island and each corresponding objective is reviewed by the RICPG and maintained. 100% of the attributes 19-36 are in place.

Attribute	Done	Not Done	Priority	Comments
Attribute 19 (Epidemiologic Profile): The epidemiologic profile provides information about defined populations at high risk for HIV infection for the RICPG to consider in the prioritization process.	X		1	Each year an updated EPI Profile is done for the plan as an integral part of the planning process and a stand-alone. EPI piece is then posted on HEALTH-RI's website.
Attribute 20 (Epidemiologic Profile): Strengths and limitations of data sources used in the epidemiologic profile are described (general issues and jurisdiction-specific issues).	X		1	This has always been an integral part of the EPI Profile.
Attribute 21 (Epidemiologic Profile): Data gaps are explicitly identified in the epidemiologic profile.	X		1	Data gaps are identified in the EPI Profile and the RICPG is trained on these gaps. This year the focus was on No Identified Risk and ways to understand what that category of data meant for RI.
Attribute 22 (Epidemiologic Profile): The epidemiologic profile contains a narrative interpretation of data presented.	X		1	

Attribute 23 (Epidemiologic Profile): Evidence that the epidemiologic profile was presented to the RICPG members prior to the prioritization process.	X		1	The HIV/AIDS Epidemiologist is a "staff" Consultant to the RICPG. A calendar of trainings by the Epidemiologist reflects the integration of this data with prioritization. The RICPG also debriefs with the Epidemiologist after the prioritization exercise to ensure accuracy and quality of interpretation of information.
Attribute 24 (Community Services Assessment): The Community Services Assessment (CSA) focuses on one or more high priority populations (i.e., substantially contributing to new HIV infections in a jurisdiction) identified in the epidemiologic profile.	X		1	The CSA is incorporated into both the RICPG Committee level and the TF levels. It is comprehensive in nature and does devote attention to more than one target population.

Attribute 25 (Community Services Assessment): Data are gathered that define populations' needs in terms of knowledge, skills, attitudes, and norms.	X		1	Funded CBOs for the 2005-2008 funding period will be required to assess/gather data regarding the populations they work with. Our RFP, issued in 8/2004, requires CBOs to accomplish this upfront. In addition, the TFs will focus on target populations and be responsible for determining what assessments/surveys, etc. are needed annually. Rhode Island's HIV prevention evaluation system will be another place where the RICPG and HEALTH-RI will get their data for the CSA, particularly around knowledge, attitudes, skills and norms.
Attribute 26 (Community Services Assessment): Data are gathered that define populations' needs in terms of access to services.	X		1	This is accomplished in the TFs.
Attribute 27 (Community Services Assessment): The CSA details the target populations being served.	X		1	This is accomplished in the TFs.
Attribute 28 (Community Services Assessment): The CSA details the interventions provided to each target population.	X		1	Considerable attention has been devoted to this in both the TF workbooks and the Best Practice Workbooks.

Attribute 29 (Community Services Assessment): The CSA describes the geographic coverage of interventions or programs.	X		1	The Resource Inventory, part of the CSA, looks at current programs by geography and the HEALTH-RI HIV funded vendors are discussed and plotted as such.
Attribute 30 (Community Services Assessment): The CSA was utilized in demonstrating linkages between the application and funded interventions.	X		1	
Attribute 31 (Community Services Assessment): Evidence that prior to the prioritization process, the RICPG was provided with a summary of the CSA.	X		1	TF and Committees were involved in the discussion as to how to begin the CSA for 2004-2005
Attribute 32 (Gap Analysis): The gap analysis includes data from the epidemiologic profile and CSA.	X		1	
Attribute 33 (Gap Analysis): A gap analysis specifically identifies both met and unmet needs.	X		1	
Attribute 34 (Gap Analysis): The gap analysis identifies the portion of needs being met with CDC funds.	X		1	
Attribute 35 (Gap Analysis): Evidence that prior to the prioritization process, the RICPG was provided with a summary of the gap analysis findings.	X		1	
Attribute 36 (Gap Analysis): The gap analysis was utilized by the RICPG in demonstrating linkages between the application and funded interventions.	X		1	

Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and a community service assessment.

HEALTH-RI and RICPG agreed that the planning process for 2003-2004 needed to be augmented with various data sets and programmatic information in addition to the Epidemiologic Profile. As a result, the preparations to include numerous other information/data began in late 2002. At the May 2003 day-long meeting, a discussion about pre-selected programs/data to assist in the priority setting was presented. The programs and data represent the initial stages in 2002-2003 of the RICPG's community assessment process. They include the following:

Epidemiologic Profile

Two members of the surveillance staff presented information to the RICPG this year. Kim Kies, the HEALTH-RI data manager, presented data on the ENCORE program, syringe exchange, and CTR to the IDU and Women's Task Forces, and Dr. Hesham Aboshady, the HEALTH-RI epidemiologist, delivered specific presentations to each of the task forces based on the new epidemiological profile with 2003 data. (See Chapter 2: Epidemiological Profile).

Federal Grant from Office of Minority Health/Report

This report assisted the RICPG in deliberating additional information pertaining to the disproportionate effect HIV has on communities of color. The target populations include women of color in and newly released from prison, girls in the training school setting, Native Americans, and the Southeast Asian community. The program is statewide, with the women in prison and the girls in the training school coming from all over Rhode Island. The Native American population specifically covers urban and rural youth from Providence (the capital city), Pawtucket, Central Falls, East Providence, Newport, and the rural youth come from Charlestown and Narragansett. The rationale for the populations selected is the needs assessment completed by the RICPG, which identified gaps in HIV/AIDS prevention services. This project acted as a supplemental database to obtain Rhode Island community assessment information, so as to understand the gaps and needs of these disenfranchised, high-risk populations.

RICPG Priority Population Task Force Reports

The priority population task forces were established in 2002 to provide the RICPG with a process of "activating" the plan and as a means of organizing important community information about target populations in a more scientific manner. The task forces include MSM, Substance Using Disorders, Women, and Youth. Included in the work of all the task forces is how to deliver programs to "People Not in Treatment/People Who Don't Know Their Status" as well as communities of color.

In addition, because of the intense nature of the work of these task forces (task force meetings add an additional 4-6 hours per month per member) data and information was gathered using a series of various techniques including, focus groups, forums, surveys, population (research) studies and epidemiologic data. Experts and researchers from each target population were selected to be a part of each group and final reports that included methods of data/information collection, findings, and action steps were included in each report. Task Force members provide updates at all RICPG meetings.

The long-term maintenance of this objective is indicated in the following matrices:

Goal Two: The Rhode Island Community Planning Group identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in Rhode Island.				
Objective E In year 2005	**Activities**	**Outputs**	**Immediate Outcomes (2005)**	**Intermediate Outcomes (5 year) (2009)**
Ensured that prioritized target populations are based on an epidemiologic profile and a community service assessment.	• Conduct ongoing trainings using the Office of HIV & AIDS Epidemiologist for: RICPG, consultants and HEALTH-RI staff regarding community needs assessment and epidemiologic profile • Conduct assessments that obtain data from supplemental areas to augment epidemiologic profile through the established task forces of the RICPG • Use documented, standardized methods via workbook for prioritizing populations	**Attribute 37** (Target Populations): Evidence that the size of at-risk populations was considered in setting priorities for target populations **Attribute 38** (Target Populations): Evidence that a measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence available, was considered in setting priorities for target populations. **Attribute 39** (Target Populations): Evidence that the prevalence of risky behaviors in the population was considered in setting priorities for target populations. **Attribute 40** (Target Populations): Target populations are defined by transmission risk, gender, age, race/ethnicity, HIV status, and geographic location. **Attribute 41** (Target Populations): Target populations are rank ordered by priority, in terms of their contribution to new HIV infections.	♦ Maintain attributes throughout the year ♦ Attributes 37 – 41 are incorporated into written RICPG documents ♦ 100% attainment of Attributes 19-36 annually	The RICPG continues to identify priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in Rhode Island and each corresponding objective is reviewed by the RICPG and maintained. 100% of the attributes 37-41 are in place.

Attribute	Done	Not Done	Priority	Comments
Attribute 37 (Target Populations): Evidence that the size of at-risk populations was considered in setting priorities for target populations.	X		1	The Prioritization Workbook demonstrates that TFs integrated size into their planning.
Attribute 38 (Target Populations): Evidence that a measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence available, was considered in setting priorities for target populations.	X		1	Found in Prioritization Workbook.
Attribute 39 (Target Populations): Evidence that the prevalence of risky behaviors in the population was considered in setting priorities for target populations.	X		1	Found in Prioritization Workbook.
Attribute 40 (Target Populations) Target populations are defined by transmission risk, gender, age, race/ethnicity, HIV status, and geographic location.	X		1	Found in Prioritization Workbook.
Attribute 41 (Target Populations): Target populations are ranked by priority, in terms of their contribution to new HIV infections.	X		1	Found in Prioritization Workbook.

Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance and acceptability.

On the next page is the matrix that describes the elements associated with the selection of prevention activities/interventions for identified target populations in Rhode Island. The table reflects two important issues:

1. Rhode Island based its selections on behavioral & social science, outcome effectiveness
2. The program has been adequately tested with intended target populations for cultural appropriateness, relevance and acceptability.

Goal Three

Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan and evaluates the progress of this by increasing RICPG member perceptions across the five year grant process as well as monitoring intermediate outcomes of the process associated with this objective.

- Indicator E.3: Percent of prevention interventions supporting activities in the health department CDC funded application specified as a priority in the comprehensive HIV prevention plan.
- Indicator E.4: Percent of health department-funded prevention/supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.

Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.

The RICPG has always built this objective into the plan process by ensuring that the RICPG has equal and timely opportunity to review the plan and the cooperative. HEALTH-RI involves RICPG in the review and edits of the cooperative. Furthermore, both the plan and the cooperative are matched for congruence and each year RICPG members get to scrutinize both documents for this cohesiveness. It is estimated that the 2005 cooperative is about 90 to 95% congruent with the plan. The small difference accounts for the necessary management and fiscal goals of HEALTH-RI that are not reflected in the plan.

Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan and evaluate the progress of this by increasing RICPG member perceptions across the five year grant process, as well as monitoring intermediate outcomes of the process associated with this objective.				
Objective G In year 2005	**Activities**	**Outputs**	**Immediate Outcomes (2005)**	**Intermediate Outcomes (5 year) (2009)**
Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.	• Draft Plan • Draft cooperative letter of concurrence ▪ Draft of both documents to RICPG ▪ Both written with same priorities	**Attribute 49** (Comprehensive Plan): Explicit demonstration of linkages between the comprehensive HIV prevention plan and the health department application to CDC for federal funding. **Attribute 50 (Comprehensive Plan):** Letter of Concurrence.	• Establish Attributes 49-50 by September 2005 • Maintain attributes throughout the year • Attributes 49-50 are incorporated into written RICPG documents by 12/05 • 100% attainment of Attributes 49-50 by 12/05	The RICPG continues to monitor that the RICPG priority populations and interventions are consistent with the Cooperative Agreement and funding priorities, and each corresponding objective is reviewed by the RICPG and maintained. 100% of the attributes 49-52 are in place.

Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

HEALTH-RI issued a Request for Proposals (RFP) for HIV Prevention services on August 13, 2004. In order to meet the needs of Rhode Islanders and the CDC guidelines, the following information was used in the introduction of the RFP. The RFP clearly links the funding of prevention services to the RICPG. In addition, CDC guidance on best practices, prevention for positives and rapid testing are presented to prospective applicants.

This RFP addresses the comprehensive HIV/AIDS prevention and Viral Hepatitis care coordination service needs identified by HEALTH-RI's Office of HIV & AIDS. Taking a broader, more comprehensive approach to HIV prevention is a priority based on the recommendations from the Rhode Island Community Planning Group for HIV Prevention (RICPG) and the guidance from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). This RFP will fund agencies and partnerships that demonstrate their capacity to deliver on the comprehensive approach HEALTH-RI seeks.

This RFP is unique because of the integration of prevention for high-risk individuals and prevention for people living with HIV/AIDS and viral hepatitis. HIV and viral hepatitis prevention services are expected to begin on January 1, 2005 and will replace previous funded HIV and viral hepatitis Prevention initiatives that end December 31, 2004. Ryan White funded interventions for people living with HIV/AIDS replaces previous primary prevention activities that end March 31, 2005. The Ryan White funded interventions will begin on April 1, 2005. Applicants are strongly encouraged to be familiar with the information in this section of the RFP as it represents new requirements that supercede any previous requirements and guidance. This section outlines specifics of receiving funding for Comprehensive HIV/AIDS Prevention and Viral Hepatitis Care Coordination Services in Rhode Island.

A LOOK AT PAST, PRESENT AND FUTURE … ADVANCING HIV PREVENTION

The CDC's HIV prevention activities over the past two decades have focused on helping ***uninfected persons at high-risk for acquiring HIV change and maintain behaviors to keep them uninfected.*** Presently we adhere to this model and despite the successes of these efforts in reducing HIV incidence in the late 1980's and early 1990's, the number of new HIV infections is estimated to have remained stable at approximately 40,000 per year. The number of persons living with HIV continues to increase due to advanced treatment and drug therapy.

With this in mind, the CDC is emphasizing three primary areas of HIV prevention and these areas signify the future of HIV prevention funding:

1. **Early detection** of persons who are HIV positive and referral to treatment and care services.
2. **Prevention for persons living with HIV and viral hepatitis.**
3. **Prevention for persons who are at high-risk for HIV and viral hepatitis infection.**

To assist in this effort, the category of services in this RFP emphasizes prevention with persons living with HIV and viral hepatitis among the targeted high-risk populations identified by the RICPG; HIV counseling, testing and referral to enhance the likelihood of knowing one's HIV status; and ***proven effective*** prevention programs with high-risk individuals. Viral hepatitis care coordination is a Rhode Island program of client-centered education and referral coordination services performed by a licensed substance abuse counselor.

Applicants are encouraged to refer to CDC web sites for additional information (http://www.cdc.gov/hiv/partners/ahp.htm#journal).

A CLOSER LOOK AT THE SPECIFIC PROGRAM INTERVENTION COMPONENTS

1. **EARLY DETECTION: HIV counseling and testing of previously unknown persons who are HIV positive, and referral to treatment and care services**

In the past, HEALTH-RI has funded HIV counseling, testing and referral services to ensure that uninsured and indigent individuals could access confidential and anonymous HIV testing statewide. In this RFP, HEALTH-RI seeks an applicant to continue to provide confidential and anonymous HIV testing statewide. Applicants must base their response on the most recent guidance from the CDC at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm.

In addition, agencies applying for harm reduction, HIV prevention case management, health education/risk reduction and minority health categories are asked to seriously consider including a rapid testing HIV component to their program. For guidance, community based agencies are strongly advised to review *Advancing HIV Prevention's Rapid Testing in Non-Clinical Settings* (available at http://www.cdc.gov/hiv/partners/ahp.htm#journal).

2. PREVENTION FOR PERSONS LIVING WITH HIV

As a new initiative, HEALTH-RI is seeking applications for HIV prevention programs for people living with HIV. Applicants are expected to be familiar with *Advancing HIV Prevention* (available at http://www.cdc.gov/hiv/partners/ahp.htm#journal) and *Incorporating Prevention into the Medical Treatment of People Living with HIV* (available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm and http://hab.hrsa.gov/special/pop_grantee.htm). Emphasis is being placed on interventions in clinical settings, providing services to people living with HIV/AIDS and viral hepatitis. Successful applicants in this category will be awarded funding from the Ryan White Care Act Title II program. Applicants will need to document that they are servicing people living with HIV/AIDS (PLWHA) and that there no other funding source for these services. Ryan White Care Act funds can be used for "payer of last resort" only.

It is important that the applicant consults the *Rhode Island Comprehensive Plan for HIV Prevention* and notes the prioritization of targeted populations. Applicants for HIV

prevention for positives must specify the specific targeted population (e.g., HIV positive men who have sex with men, etc.) they intend to reach with these funds and they must be consistent with priorities set by the RICPG in the *Rhode Island Comprehensive Plan for HIV Prevention*. The *Rhode Island Comprehensive Plan for HIV Prevention* is available on the HEALTH-RI web site at http://www.health.ri.gov. Applicants are also encouraged to view the *Rhode Island Comprehensive Strategic Plan for the Prevention and Control of Viral Hepatitis* available from the Office of HIV & AIDS.

3. PREVENTION FOR PERSONS WHO ARE AT HIGH-RISK FOR HIV INFECTION

For the purposes of this proposal, the definition of an individual at high risk for HIV infection is someone who:

- has had unprotected sex with a person who is living with HIV,
- has shared injecting equipment in a high-prevalence setting or with a person who is living with HIV,
- has unprotected sex in exchange for money or drugs,
- has multiple (greater than five) or anonymous unprotected sex or needle-sharing partners, and/or,
- has been diagnosed with a sexually transmitted disease within the last 6 months.

Again, applicants for this area of concern must consult the *Rhode Island Comprehensive Plan for HIV Prevention* and target one or more of the specific populations noted in this plan.

In addition, the programs selected for funding must be proven effective prevention programs for persons who are at high-risk for HIV infection. Extensive research by the CDC has identified acceptable interventions for high-risk people from the following:

1. The ***Diffusion of Effective Behavioral Interventions*** **(**DEBI) is a group of interventions that CDC is recommending because they are proven effective and CDC has trainings and materials (curriculum) that agencies can have without cost. There are DEBIs for high risk and PLWHA. DEBIs were proven effective by outcome evaluation.

2. The ***Replicable Effective Programs*** (REP) are an additional listing of effective programs. However CDC does not have trainings and materials available for agencies at this time. Applicants may obtain contact information about the REPs from the CDC web site.

3. ***Effective local programs*** that use a science based or theoretical model such as peer counseling, natural helper, social development model, stages of change, etc. are also eligible for funding. The applicant must prove their program's need and appropriateness by conducting a formative evaluation and include the results in this application. This type of intervention requires assessments based on previous provision of programs and/or assessment information pertaining to the populations targeted.

It is critical for the applicant to understand that if your agency selects a HIV prevention program focusing on high-risk individuals then it must adhere to one of the aforementioned models. (The entire RFP by be viewed at the HEALTH-RI website http://www.health.ri.gov/news.htm)

Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan and evaluate the progress of this by increasing RICPG member perceptions across the five year grant process as well as monitoring intermediate outcomes of the process associated with this objective.				
Objective H In year 2005	**Activities**	**Outputs**	**Immediate Outcomes (2005)**	**Intermediate Outcomes (5 year-2009)**
Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.	• Conduct vendor activities that are reflective of plan • RFP process is in place and reflective of plan • New contracts established and are reflective of plan • Build into RICPG process opportunity for RICPG members to agree that recommended funded vendors and their interventions are consistent with their Plan	**Attribute 51 (Comprehensive Plan):** Explicit demonstration of linkages between the comprehensive HIV prevention plan and funded interventions. **Attribute 52 (Community Services Assessment):** Explicit demonstration that the RICPG has used the CSA to determine whether interventions were funded according to the comprehensive HIV prevention plan.	• Establish Attributes 51-52 by September 2005 • Maintain attributes throughout the year • Attributes 51-52 are incorporated into written RICPG documents by 12/04 • 100% attainment of Attributes 51-52 by 12/04	The RICPG continues to develop and monitor the fact that the RICPG priority populations and interventions are consistent with the Cooperative Agreement and funding priorities and each corresponding objective is reviewed by the RICPG and maintained. 100% of the attributes 49-52 are in place.

Section 2
2003 Rhode Island Epidemiologic Profile of HIV/AIDS for Prevention and Community Planning

June 2004

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Preface

On behalf of the Rhode Island Department of Health Office of HIV & AIDS, we are pleased to present the 2004 HIV/AIDS Epidemiologic Profile. Our goal this year was to create a report both useful and understandable.

As you may be aware, the data found within is primarily gathered by the Rhode Island Department of Health as part of our public health assurance function. As part of this responsibility, the reportable diseases of HIV and AIDS are diligently recorded, analyzed and monitored by our group of professionals with the end result being a continuous loop back to the community.

Throughout the year the information found within has been shared with numerous groups and organizations as a means of educating as well as receiving feedback from them. One important group instrumental for assisting the Office of HIV & AIDS with this document has been the Rhode Island Community Planning Group for HIV Prevention. We would like to take this time to thank them for their contribution.

I would be remiss if I did not mention the dedication and hard work of several contributors and editors of this work. Dr. Hesham Aboshady, the Office of HIV & AIDS Epidemiologist, is the primary author of this profile and has worked hand in hand with the community to produce his first Epidemiologic Profile for the state. Drs. Bandy and Fulton both assisted in the review and editing of this document and we are grateful for their contributions and continued guidance. Lucille Minuto also an editor, helped immensely with formatting and design.

We hope you find this edition of our HIV/AIDS Epidemiologic Profile a valuable resource for planning, grant writing and projecting needs of high-risk populations. As always, your input is important and we'd love to hear what you think about this report. By the way, if you'd like to share this profile with others, please go to www.healthri.org for a complete copy of this profile.

Sincerely,
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Chief Administrator
Rhode Island Department of Health
Division of Disease Control and Prevention
Office of HIV & AIDS

Rhode Island Department of Health

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Management Information Systems
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Introduction

The Epidemiologic Profile provides detailed information about the current HIV/AIDS epidemic in Rhode Island. The profile aims to describe the general population of Rhode Island, HIV infected persons, persons with AIDS, and those that are at risk of HIV infection.

The Epidemiologic Profile is part of the commitment of the Rhode Island Department of Health to disseminate health related information to those who need to know. It is designed to serve as a tool at the disposal of the HIV/AIDS Community Planning Group (CPG) to assist them in setting priorities for HIV prevention and care efforts in the state of Rhode Island.

Organization of the Epidemiologic Profile

This report is organized around three core epidemiological questions. Each question will be represented in a separate chapter, which will include relevant data and interpretations. The core epidemiologic questions are:

1) What are the sociodemographic characteristics of the population of Rhode Island?
   This section provides information on the demographic and socioeconomic characteristics of Rhode Island.
2) What is the impact of the HIV/AIDS epidemic on Rhode Island?
   This section examines the scope of the HIV/AIDS epidemic in Rhode Island. This section is divided into two parts; the first part addresses AIDS cases and the second part addresses HIV infected (not AIDS) individuals
3) Who is experiencing differential impact from the HIV/AIDS epidemic in Rhode Island?
   This section addresses certain populations that have been disproportionately affected by the epidemic. This section relies heavily on HIV data (not AIDS) as it aims to address current trends in HIV transmission.

HIV/AIDS Surveillance in Rhode Island

Surveillance mandate

In accordance with Rhode Island's General Laws, Chapter 23 and the "Rules and Regulations for the Reporting of Communicable Diseases" of the Rhode Island Department of Health, both HIV and AIDS are reportable to the Office of HIV & AIDS by hospitals, laboratories and licensed health care professionals.

Case definitions:

In its collection, assessment, and aggregation of HIV and AIDS reports, the Rhode Island Department of Health conforms to surveillance case definitions of HIV and AIDS promulgated by the Centers for Disease Control and Prevention (CDC) and revised over time. Case definitions have been published in 1986, 1987, 1992, and 1999.

- CDC. Classification system for human T-lymphotropic virus type III/lymphadenopathy-associated virus infections. MMWR 1986; 35:334.
- CDC. Revision of the CDC surveillance case definition for acquired immunodeficiency syndrome. MMWR 1987; 36:1-15S.
- CDC. 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults. MMWR 1992; 41(RR-17).
- CDC. Appendix: Revised Surveillance Case Definition for HIV Infection. MMWR 1999; 48(RR13); 29-31.

It is important to note that revisions in the CDC surveillance definitions of HIV and AIDS may cause discontinuities in trend data. Between 1992 and 1993, for example, the number of AIDS cases in Rhode Island and in the United States as a whole increased dramatically because of CDC's expanded surveillance case definition for AIDS.

Data Sources

Case surveillance of AIDS was initiated in Rhode Island in 1983, and HIV surveillance began in 1989. These surveillance systems provide information on risk factors, patient demographics, and the clinical manifestations of disease over time. The present Epidemiologic Profile relies

primarily on these case surveillance data. However, the Office of HIV & AIDS utilizes an array of data sources to establish the most complete and accurate picture of HIV and AIDS in Rhode Island and the populations at highest risk for infection. The list below identifies many of the sources of information used by the Office of HIV & AIDS.

HARS (HIV/AIDS Reporting System)—Includes all reported cases of AIDS since 1983 and HIV positive test results since 1989.

HIVREP (HIV Reporting System)—Preceded the HARS system. Contains reports of illness by lab test code and therefore is not an unduplicated count of cases.

HIV Unique-Identifier Reporting System—Implemented in 2000, providers are required to report all cases of HIV infection with a unique patient identifier and without names. Provides an unduplicated count of cases.

HIVSER (HIV Serology Database) —Includes all positive and negative HIV test results submitted to the Rhode Island Department of Health State Laboratories.

CTR (Counseling, Testing and Referral Database)—Provides information on all HIV tests and services provided at CTR sites funded by the Rhode Island Department of Health.

BRFSS (Behavioral Risk Factor Surveillance System)

YRBSS (Youth Risk Behavior Survey)

STD Database—Information from the Rhode Island Department of Health's Office of Communicable Diseases that is used for identifying at-risk populations and co-infection.

Tuberculosis Database—Information from the TB Surveillance System is matched with HARS to identify missing cases of AIDS in the form of unreported co-infections (HIV-TB) as cases of AIDS.

Cancer Registry—Information used for identifying individuals with AIDS-defining malignancies.

Social Security Death Index/Rhode Island State Medical Examiner—Two sources used to identify deaths attributed to AIDS and also to follow-up on previously reported cases.

Hospital Medical Records—Patient medical records are utilized in AIDS validation studies and in the follow-up of previously reported cases.

ACI Medical Records—All convicted inmates are tested for HIV at intake in the ACI (Adult Correctional Institute). The system in place has provisions to eliminate duplicate HIV positive test results.

Data Limitations

The ideal HIV/AIDS surveillance system would be capable of detecting and accurately detailing all new HIV infections so that HIV prevention programs could most accurately reflect the current factors causing people to be at risk. Since 1983, the Department of Health has required the reporting of all AIDS cases and since 1989 has required all HIV positive test results to be reported. The HIV positive test results have been collected without names or other identifying information in order to protect the anonymity of patients. However, this "no names/no identifiers" system fostered duplication and incomplete information. As a result, a new HIV reporting system was implemented in 2000 which uses a unique identifier code to maintain patient anonymity, but will eliminate case duplication and will allow for follow-up. This new HIV reporting system greatly improves the ability of the Office of HIV & AIDS to conduct HIV surveillance now and in the future.

Despite the recent changes in the reporting of HIV, it is important to note that a newly reported case of HIV (or in the past an HIV positive test) does not necessarily signify a new HIV infection. Many individuals are unaware or are unwilling to be tested for HIV and therefore may be tested and diagnosed long after the initial infection occurred. Moreover, an

individual infected with HIV may not progress to AIDS for many years, thereby making AIDS data potentially unreliable for the purpose of detailing current transmission patterns.

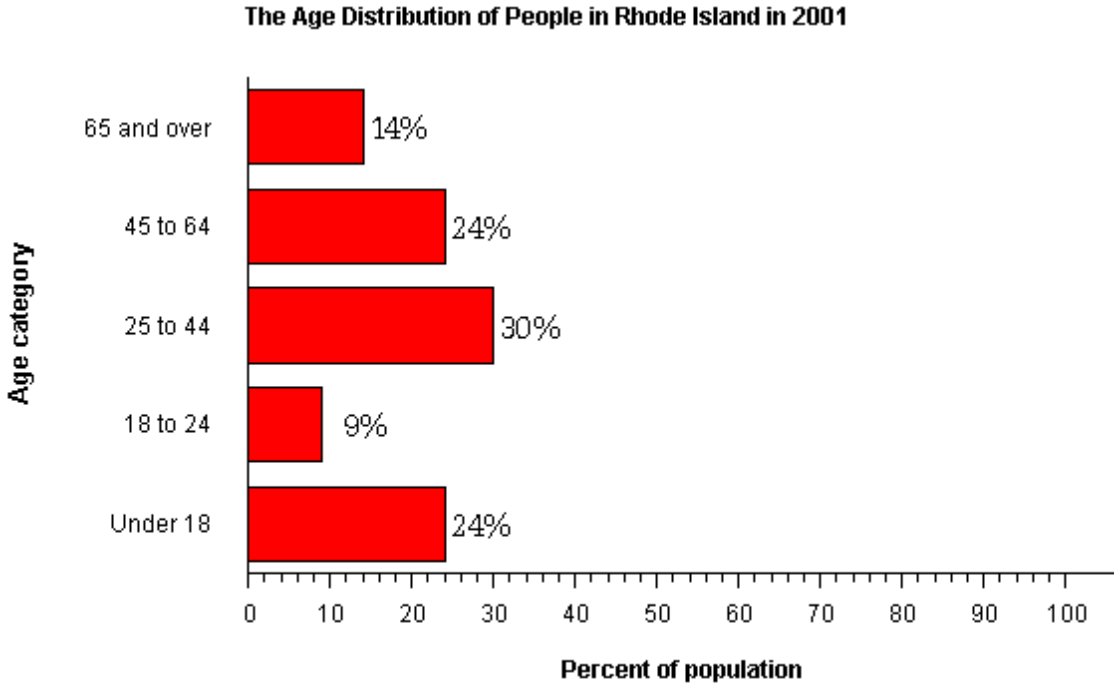
Third parties, most frequently health care providers, report much of the data needed by the Office of HIV & AIDS. As a result, these reports rely on the patients and providers to accurately and completely disclose relevant information pertaining to risk factors, demographic characteristics and clinical history.

Core Epidemiologic Questions

(1) What are the sociodemographic characteristics of the population of Rhode Island?

Rhode Island is a small but densely populated state; it has the distinction of being the second most densely populated state in the United States. In 2001, Rhode Island had a household population of 1.0 million—**529,000 (52 percent) females** and **491,000 (48 percent) males**. The **median age was 37.5 years**. **Twenty-four percent of the population were under 18 years** and **14 percent were 65 years and older**.

Figure 1. Age Distribution of People in Rhode Island in 2001.



Source: U.S. Census Bureau, 2001 Supplementary Survey

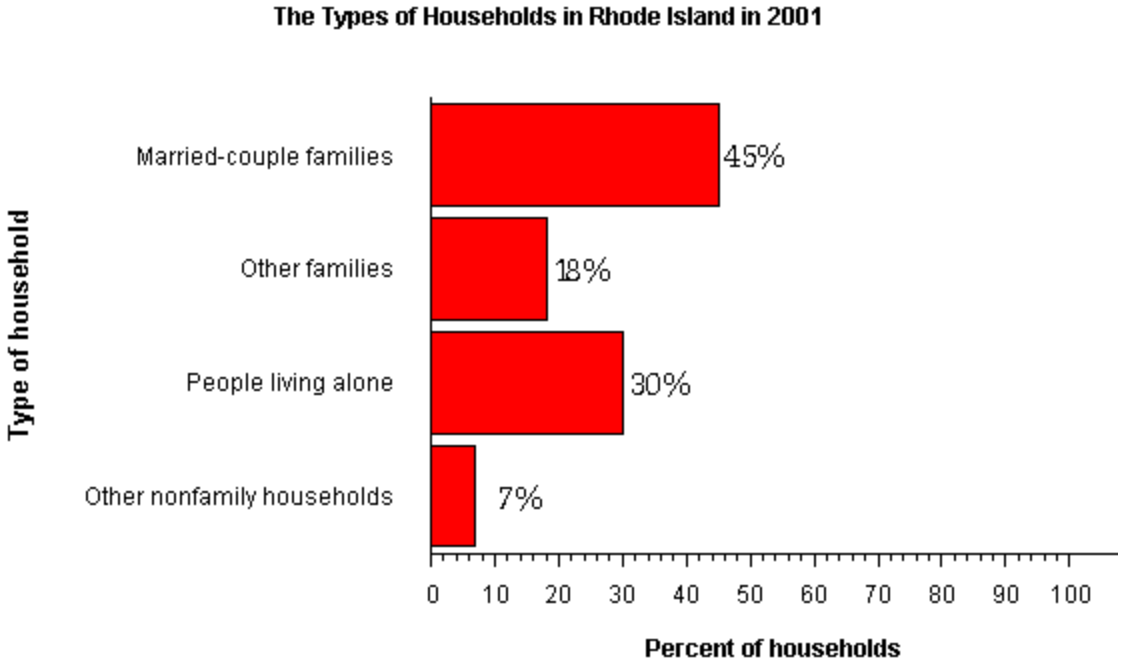
For people reporting one race alone, **87 percent were White**; **5 percent were Black or African American**; **less than 0.5 percent were American Indian and Alaska Native; 3 percent were Asian; less than 0.5 percent were Native Hawaiian and Other Pacific Islander, and 5 percent were some other race**. Two percent reported two or more races.

Nine percent of the people in Rhode Island were Hispanic. **Eighty-two percent of the people in Rhode Island were White non-Hispanic**. People of Hispanic origin may be of any race.

HOUSEHOLDS AND FAMILIES: In 2001 there were 406,000 households in Rhode Island. The average household size was 2.51 people.

Families made up 63 percent of the households in Rhode Island. This figure includes both married-couple families (45 percent) and other families (18 percent). Non-family households made up 37 percent of all households in Rhode Island. Most of the non-family households were people living alone, but some were comprised of people living in households in which no one was related to the householder.

Figure 2. Types of Households in Rhode Island 2001.

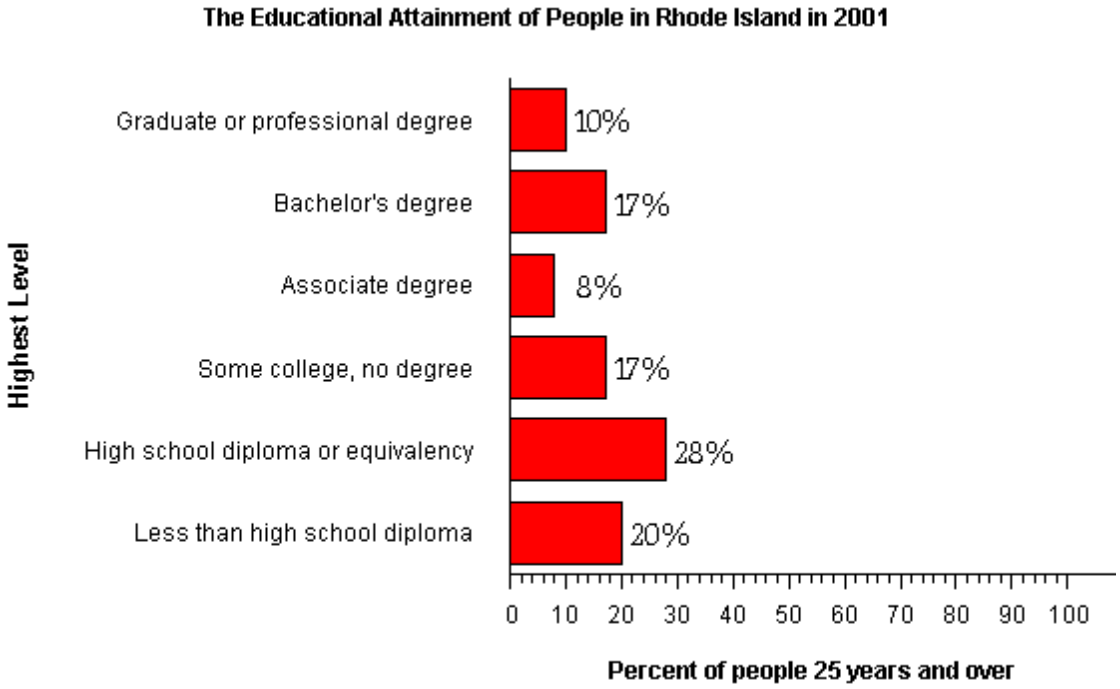


Source: U.S. Census Bureau, 2001 Supplementary Survey

EDUCATION: In 2001, 80 percent of people 25 years and over had at least graduated from high school and 27 percent had a bachelor's degree or higher. Among people 16 to 19 years old, 9 percent were dropouts; they were not enrolled in school and had not graduated from high school.

The total school enrollment in Rhode Island was 264,000 in 2001. Preprimary school enrollment was 28,000 and elementary or high school enrollment was 172,000 children. College enrollment was 64,000.

Figure 3. The Educational Attainment of People in Rhode Island in 2001.



Source: U.S. Census Bureau, 2001 Supplementary Survey

DISABILITY: In Rhode Island, among people at least five years old in 2001, 16 percent reported a disability. The likelihood of having a disability varied by age - from 7 percent of people 5 to 20 years old, to 14 percent of people 21 to 64 years old, and to 42 percent of those 65 and older.

INCOME: The median income of households in Rhode Island was $42,784. Seventy-six percent of the households received earnings and 17 percent received retirement income other than Social Security. Twenty-eight percent of the households received Social Security. The average income from Social Security was $12,019. These income sources are not mutually exclusive; that is, some households received income from more than one source.

POVERTY AND PARTICIPATION IN GOVERNMENT PROGRAMS: In 2001, 12 percent of people were in poverty. Seventeen percent of related children under 18 were below

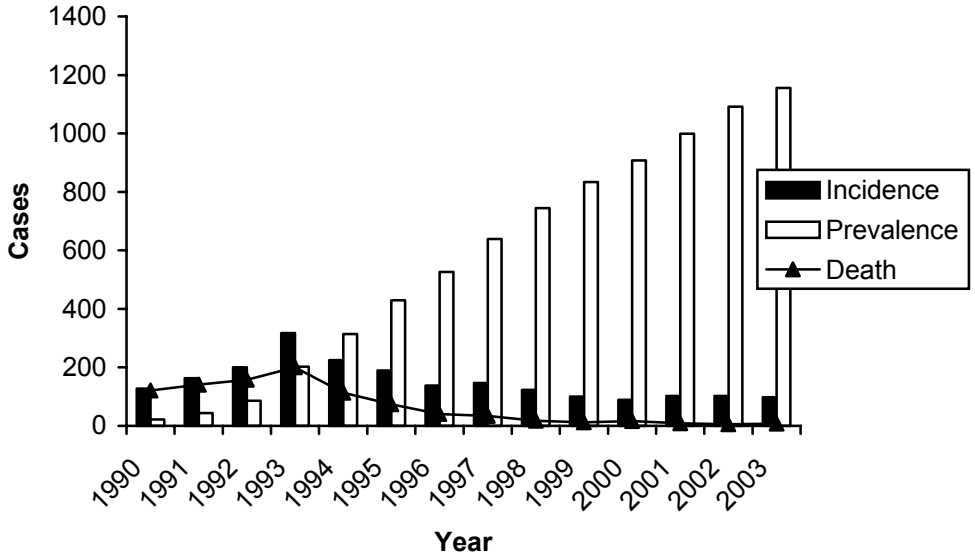
the poverty level, compared with 11 percent of people 65 years old and over. Nine percent of all families and 25 percent of families with a female householder and no husband present had incomes below the poverty level. Twenty percent of the households in Rhode Island received means-tested public assistance or non-cash benefits.

(2) What is the impact of the HIV/AIDS epidemic on Rhode Island?

AIDS in Rhode Island

As of December 31, 2003, a total of 2,480 cases of AIDS have been diagnosed in Rhode Island residents. Since 1993, the incidence, which is the number of new cases of AIDS, and deaths among AIDS cases have decreased dramatically, coinciding with the widespread use of more effective treatments. As seen in Figure 1, AIDS incidence has decreased by 69% (from 317 new cases in1993 to 99 new cases in 2002). During the same time period the AIDS prevalence, or the total number of AIDS cases living in Rhode Island each year, has increased 5 fold (from 203 cases in 1993 to 1,092 cases in 2002).

Figure 4. Rhode Island AIDS Incidence, Prevalence, and Deaths, 1990-2003



Of the 2,480 cases diagnosed, the majority where males (77%), between 30-39 (45%) years of age and White (57%). Collectively intravenous drug use (IDU) was the most common mode of

exposure. Table 1, shows a detailed demographic profile of all AIDS cases diagnosed since 1982. Table 1 shows the demographic characteristics of all 2,480 cases.

Table 1. Demographic Characteristics of RI AIDS Cases 1982-2003

Demographic Characteristics	RI Cases 1982-2003
Gender	
Male	1,903 (77%)
Female	577 (23%)
Total	2,480 (100%)
Age Group	
<5	21 (1%)
5-12	6 (<1%)
13-19	10 (<1%)
20-29	383 (15%)
30-39	1,166 (45%)
40-49	723 (29%)
50+	221 (9%)
Total	2,480 (100%)
Race/Ethnicity	
Hispanic-All Races	427 (17%)
American Indian/Alaska Native	22 (1%)
Asian	*
Legacy Asian/Pacific Islander	13 (<1%)
African American	613 (25%)
Native Hawaiian/ Pacific Islander	*
White	1,404 (57%)
Total	2,480 (100%)
Exposure Category	
MSM	879 (35%)
IDU	895 (36%)
MSM/IDU	123 (5%)
Hemophilia/Coagulation Disorder	38 (2%)
Heterosexual Contact	479 (19%)
Transfusion/Transplant	28 (1%)
Mother with HIV	26 (1%)
No Risk Reported	12 (<1%)
Total	2,480 (100%)
* Cell contained less than five cases	

Epidemiological Trends of AIDS in Rhode Island

The demographic profile of those diagnosed with AIDS has changed over time. Tables 2 and 3 show the demographic characteristics of AIDS cases by year of diagnosis.

Table 2. Demographic Characteristics of RI AIDS Cases by Year of Diagnosis 1993-1997

Demographic Characteristics	1994	1995	1996	1997	1998
Gender					
Male	169 (75%)	127 (73%)	91 (73%)	99 (72%)	89 (74%)
Female	57 (25%)	48 (27%)	34 (27%)	38 (28%)	32 (26%)
Total	226 (100%)	175 (100%)	125 (100%)	137 (100%)	121 (100%)
Age Group					
<13	<5 *	<5 *	<5 *	<5 *	<5 *
13-19	<5 *	<5 *	<5 *	<5 *	<5 *
20-29	36 (16%)	20 (11%)	8 (6%)	12 (9%)	11 (9%)
30-39	103 (46%)	84 (48%)	67 (54%)	62 (46%)	54 (45%)
40-49	63 (28%)	52 (30%)	35 (28%)	49 (36%)	43 (36%)
50+	24 (11%)	16 (9%)	15 (12%)	12 (9%)	10 (8%)
Total	226 (100%)	175 (100%)	125 (100%)	137 (100%)	121 (100%)
Race/Ethnicity					
Hispanic-All Races	44 (19%)	39 (22%)	22 (18%)	33 (24%)	34 (28%)
American Indian/Alaska Native	<5 *	<5 *	<5 *	<5 *	<5 *
Asian	<5 *	<5 *	<5 *	<5 *	<5 *
African American	51 (23%)	45 (26%)	38 (30%)	37 (27%)	33 (27%)
Native Hawaiian/ Pacific Islander	<5 *	<5 *	<5 *	<5 *	<5 *
White	129 (57%)	87 (50%)	63 (50%)	65 (47%)	52 (43%)
Total	226 (100%)	175 (100%)	125 (100%)	137 (100%)	
					121 (100%)
Exposure Category					
MSM	78 (35%)	56 (32%)	33 (26%)	43 (31%)	34 (28%)
IDU	89 (39%)	71 (41%)	56 (45%)	51 (37%)	42 (35%)
MSM/IDU	12 (5%)	10 (6%)	9 (7%)	5 (4%)	5 (4%)
Hemophilia/Coagulation Disorder	<5 *	<5 *	<5 *	<5 *	<5 *
Heterosexual Contact	46 (20%)	33 (19%)	24 (19%)	35 (26%)	35 (29%)
Transfusion/Transplant	<5 *	<5 *	<5 *	<5 *	<5 *
Mother with HIV	<5 *	<5 *	<5 *	<5 *	<5 *
No Risk Reported	<5 *	<5 *	<5 *	<5 *	<5 *
Total	226 (100%)	175 (100%)	125 (100%)	137 (100%)	121 (100%)
* Cell contained less than five cases					

Table 3. Demographic Characteristics of RI AIDS Cases by Year of Diagnosis 1998-2003

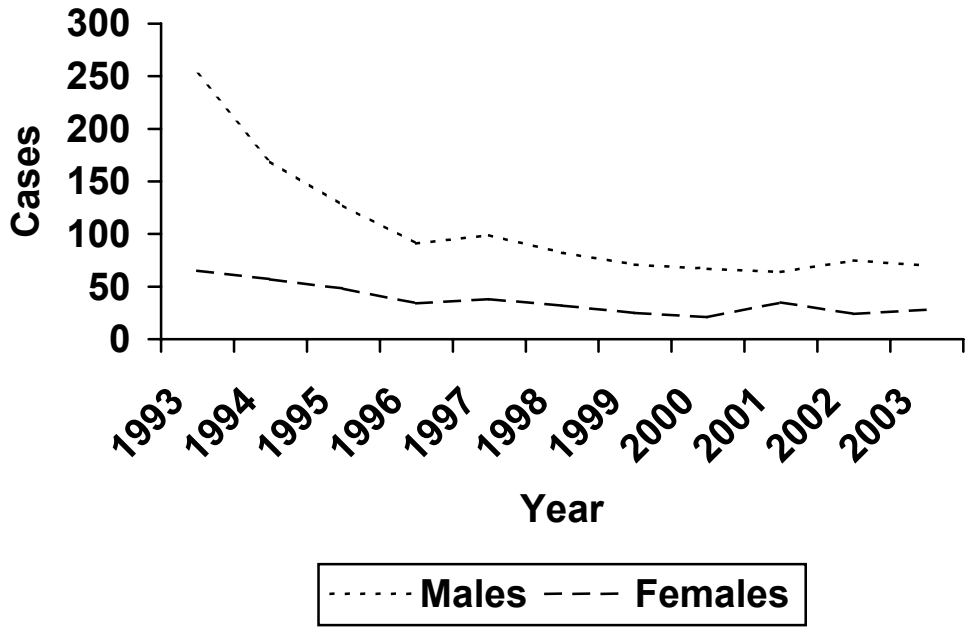
Demographic Characteristics	1999	2000	2001	2002	2003
Gender					
Male	71 (74%)	67 (76%)	64 (65%)	75 (75%)	70 (71%)
Female	25 (26%)	21 (24%)	35 (35%)	24 (25%)	28 (29%)
Total	96 (100%)	88 (100%)	99 (100%)	99 (100%)	98 (100%)
Age Group					
<13	<5 *	<5 *	<5 *	<5 *	<5 *
13-19	<5 *	<5 *	<5 *	<5 *	<5 *
20-29	5 (5%)	13 (15%)	14 (14%)	8 (8%)	11 (11%)
30-39	31 (32%)	34 (39%)	37 (37%)	37 (37%)	34 (35%)
40-49	41 (43%)	32 (36%)	31 (31%)	41 (41%)	37 (38%)
50+	18 (19%)	8 (9%)	15 (15%)	12 (12%)	12 (12%)
Total	96 (100%)	88 (100%)	99 (100%)	99 (100%)	98 (100%)
Race/Ethnicity					
Hispanic-All Races	24 (25%)	16 (18%)	27 (27%)	18 (18%)	24 (24%)
American Indian/Alaska Native	<5 *	<5 *	<5 *	<5 *	<5 *
Asian	<5 *	<5 *	<5 *	<5 *	<5 *
African American	16 (17%)	26 (30%)	30 (30%)	32 (33%)	37 (38%)
Native Hawaiian/ Pacific Islander	<5 *	<5 *	<5 *	<5 *	<5 *
White	55 (57%)	41 (47%)	40 (40%)	47 (48%)	36 (37%)
Legacy Asian/Pacific Islander	<5 *	<5 *	<5 *	<5 *	<5 *
Total	96 (100%)	88 (100%)	99 (100%)	99 (100%)	98 (100%)
Exposure Category					
MSM	25 (26%)	23 (26%)	17 (17%)	28 (38%)	27 (28%)
IDU	34 (35%)	32 (36%)	37 (37%)	32 (32%)	26 (27%)
MSM/IDU	<5 *	<5 *	<5 *	<5 *	<5 *
Hemophilia/Coagulation Disorder	<5 *	<5 *	<5 *	<5 *	<5 *
Heterosexual Contact	29 (30%)	27 (31%)	40 (40%)	34 (37%)	41 (42%)
Transfusion/Transplant	<5 *	<5 *	<5 *	<5 *	<5 *
Mother with HIV	<5 *	<5 *	<5 *	<5 *	<5 *
No Risk Reported	<5 *	<5 *	<5 *	<5 *	<5 *
Total	96 (100%)	88 (100%)	99 (100%)	99 (100%)	98 (100%)
* Cell contained less than five cases					

Gender:

The total number of reported AIDS cases in males continues to far exceed the number of female AIDS cases in Rhode Island. While there are more male cases, the gap in the number of AIDS cases between genders has shown a steady decrease since 1993. In 1993, there were 187 more cases in males versus females in Rhode Island. In 2003 there were 42 more cases in males.

While the increase in the proportion of women being diagnosed with AIDS is a national trend, this trend is more profound in Rhode Island. With Rhode Island ranking the 39th according to the total number of AIDS cases diagnosed through the year 2000 it ranked 30th according to the total number of females AIDS cases diagnosed through the year 2000.

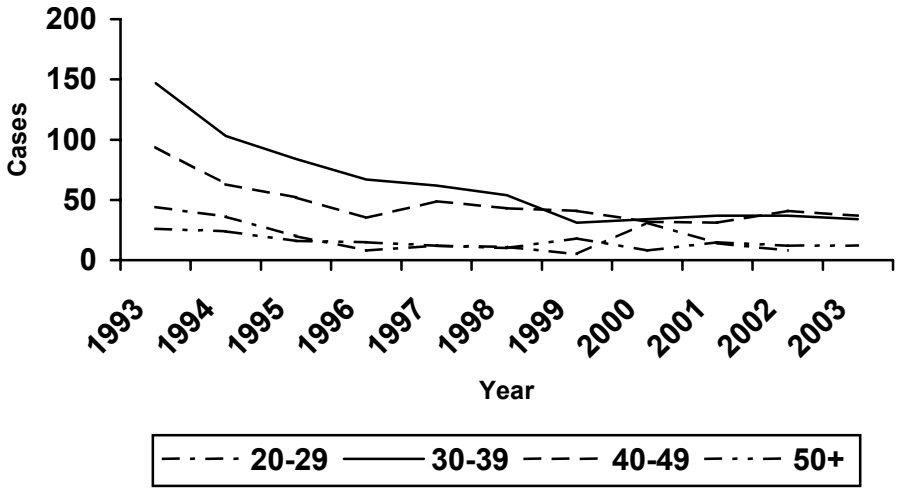
Figure 5. Rhode Island AIDS Incidence by Gender, 1993-2003



Age:

The age distribution of new AIDS case has maintained a fairly stable trend over the years. As seen in Figure 6, the rate of AIDS incidence is significantly higher in the age groups 30 to 39 and 40 to 49.

Figure 6. Rhode Island AIDS Incidence by Age, 1993-2003



Race:

Figure 7 shows that the majority of AIDS cases in Rhode Island have occurred in Whites (57%). However, 41% of the AIDS cases have occurred in African Americans and Hispanics who account for 14% of Rhode Island's population, as shown in Figure 8. African Americans experience the highest rate of disease, they account for 24% of all AIDS cases and only 5% of the total population of Rhode Island. Hispanics experience the second highest rate of disease, they account for 17% of all AIDS cases while they represent only 9% of the total population of Rhode Island.

Figure 7. Percentage of Cumulative AIDS Cases by Race in Rhode Island 1993-2003

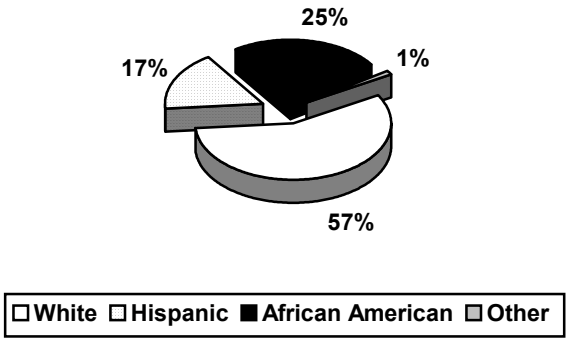
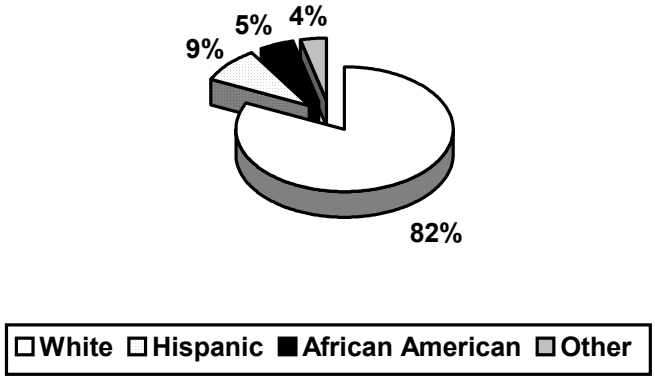


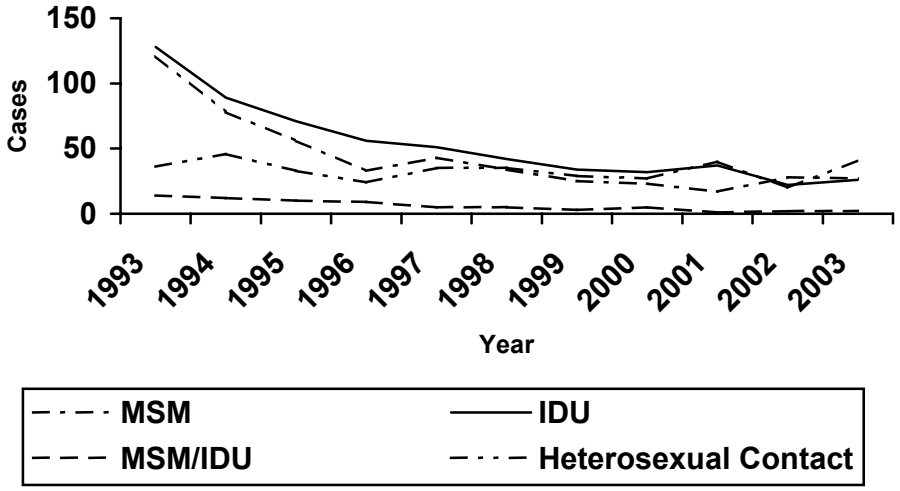
Figure 8. Percentage of Rhode Island Population by Race, 2000 Census



Exposure Category:

While men who have sex with men (MSM) and injecting drug users (IDU) have been by far the dominant exposure categories since the beginning of the epidemic, this pattern is changing. Since 1993, IDU and MSM-associated AIDS incidence have shown a downward trend, with IDU-associated AIDS incidence dropping by 83% and MSM-associated AIDS incidence dropping by 76%. AIDS cases associated with heterosexual contact on the other hand have maintained a fairly constant incidence, with modest fluctuations, in the same time period.

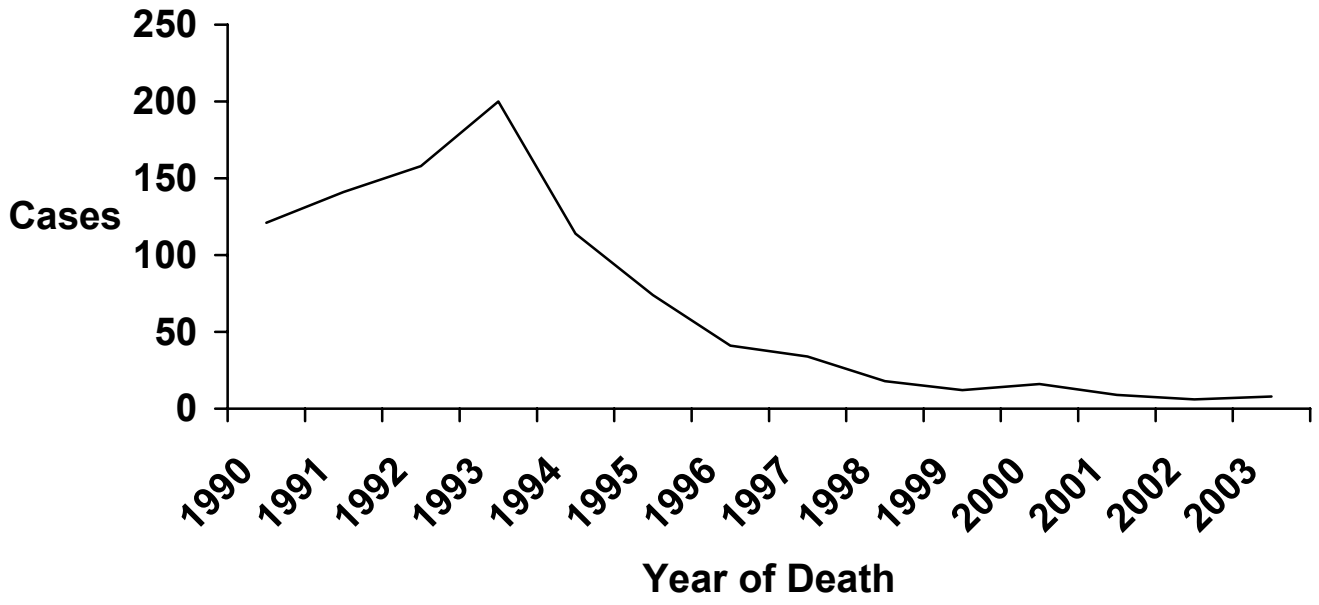
Figure 9. Rhode Island AIDS Incidence by Exposure Category, 1993-2003


150
100
50
0
Cases
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
Year
MSM
IDU
MSM/IDU
Heterosexual Contact

Death Among AIDS Cases

In Rhode Island from the beginning of the epidemic through 2003, 1,325 deaths occurred among persons with AIDS. Since 1994, with the exception of a small increase in 2000, the number of deaths has steadily declined (Figure7). The demographic profile of deaths among AIDS cases is similar to that of AIDS incidence, in regards to gender, race/ethnicity, age and exposure category distribution.

Figure 10. AIDS Deaths, RI Residents, 1990-2003



Pediatric AIDS Cases

From 1982 to 2003, 27 children between the ages of zero and 12 were diagnosed with AIDS in Rhode Island. Most cases were male (76 %) and Black (58 %). Transmission from a mother with HIV (88 %) was the most common risk factor.

Table 4. Percentage of children ages 0-12 reported with AIDS, RI residents, 1982-2002, by demographic characteristic

Demographic Characteristic	%
	(N=27)
Sex	
Male	76
Female	24
Total	100
Race/Ethnicity	
White	27
Black	58
Hispanic	*
Asian	*
Native American	*
Total	100
Risk Factor	
Mother w/ HIV	88
Pediatric Transfusion	12
Total	100
* Cell contained less than five cases	

HIV in Rhode Island

Between January 1, 2000, and December 31, 2003, there were 551 Rhode Island residents newly diagnosed with HIV and reported to the Rhode Island Department of Health. This number provides a minimum estimate of HIV infection, as it does not include HIV infected individuals who do not get tested and those who get tested anonymously.

According to the Centers for Disease Control and Prevention (CDC) there was an estimated 850,000-950,000 individuals living with HIV (not AIDS) and AIDS in the United States at the end of the year 2000. Based on this estimate there were 2,961-3,310 individuals living with HIV (not AIDS) and AIDS in the state of Rhode Island.

Reporting newly diagnosed cases of HIV in Rhode Island

The reporting of positive HIV test results has been mandatory in Rhode Island since 1989. From 1989 through 1999, reports purposely did not contain sufficient identifying information to establish the uniqueness of an individual test result with certainty, and because many people testing positive for HIV frequently received more than one test, the number of positive tests exceeded the numbers of persons with newly diagnosed HIV. For this reason, the number of positive HIV tests received annually during this period of observation was used only as a very rough indicator of the incidence of newly diagnosed HIV, influenced not only by the true incidence rate, but also by norms of HIV testing, including the rate at which high-risk individuals sought testing, the size of groups such as prison inmates for whom testing was mandatory, and the average number of additional tests sought after an initial positive test result.

From the year 2000 onward, reports of positive HIV test results have contained unique personal identifiers with which duplicate test results may be culled from the aggregate with great certainty, allowing greater confidence in the interpretation of HIV data.

There were 551 new cases of HIV diagnosed in the period from January 1, 2000, to December 31, 2003. Table 5 represents a break down of those 551 cases by demographic characteristics and year of diagnosis.

Table 5. Demographic Characteristics of HIV Cases, January 1, 2000, to December 31, 2003.

Demographic Characteristics	Number of Newly Diagnosed Cases of HIV				
	2000	2001	2002	2003	Total
Gender					
Male	84 (69.4%)	110 (73.3%)	106 (72.6%)	103 (76.9%)	403 (73.1%)
Female	37 (30.6%)	40 (26.7%)	40 (27.4%)	31 (23.1%)	148 (26.9%)
Total	121 (100%)	150 (100%)	146 (100%)	134 (100%)	551 (100%)
Age Group					
<13	<5 *	<5 *	<5 *	<5 *	<5 *
13-19	<5 *	5 (3.3%)	5 (3.4%)	<5 *	17 (3.1%)
20-29	25 (20.7%)	32 (21.3%)	36 (24.7%)	28 (20.9%)	121 (22.0%)
30-39	55 (45.5%)	59 (39.3%)	58 (39.7%)	53 (39.6%)	225 (40.8%)
40-49	31 (25.6%)	42 (28.0%)	39 (26.7%)	32 (23.9%)	144 (26.1%)
50+	7 (5.8%)	12 (8.0%)	8 (5.5%)	17 (12.7%)	44 (8.0%)
Total	121 (100%)	150 (100%)	146 (100%)	134 (100%)	551 (100%)
Race/Ethnicity					
White	41 (33.9%)	54 (36.0%)	64 (43.8%)	43 (32.1%)	202 (36.7%)
Black	38 (31.4%)	50 (33.3%)	51 (34.9)	48 (35.8%)	187 (33.9%)
Hispanic	37 (30.6%)	45 (30.0%)	31 (21.2%)	40 (29.9%)	153 (27.8%)
Asian	5 (4.1%)	<5 *	<5 *	<5 *	8 (1.5%)
Native American	<5 *	<5 *	<5 *	<5 *	<5 *
Total	121 (100%)	150 (100%)	146 (100%)	134 (100%)	551 (100%)
Risk Factor					
MSM	28 (23.1%)	48 (32.0)	43 (29.5%)	45 (33.6%)	164 (29.8%)
IDU	25 (20.7%)	27 (18.0%)	24 (16.4%)	13 (9.7%)	89 (16.2%)
MSM / IDU	<5 *	<5 *	<5 *	5 (3.7%)	9 (1.6%)
Heterosexual Contact	23 (19.0%)	29 (19.3%)	20 (13.7%)	25 (18.7%)	97 (17.6%)
Transfusion	<5 *	<5 *	<5 *	<5 *	<5 *
No Risk Specified	43 (35.5%)	43 (28.7%)	57 (39.0%)	44 (32.8%)	187 (33.9%)
Total	121 (100%)	150 (100%)	146 (100%)	134 (100%)	551 (100%)

County of Residence					
Homeless	<5 *	<5 *	<5 *	<5 *	<5 *
Bristol	<5 *	<5 *	<5 *	<5 *	9 (1.6%)
Kent	8 (6.6%)	10 (6.7%)	7 (4.8%)	4 (3.0%)	29 (5.3%)
Newport	5 (4.1%)	*	6 (4.1%)	*	19 (3.4%)
Providence	103 (85.1%)	128 (85.3%)	125 (85.6%)	122 (91.0%)	478 (86.8%)
Washington	*	6 (4.0%)	*	*	15 (2.7%)
Total	121 (100%)	150 (100%)	146 (100%)	134 (100%)	551 (100%)
* Cell contained less than five cases					

Figure 11. Rhode Island HIV Incidence 2000-2003

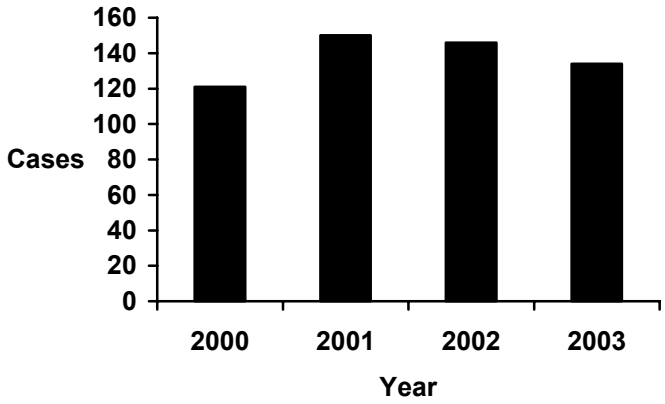


Figure 12. Rhode Island HIV Incidence by Gender 2000-2003

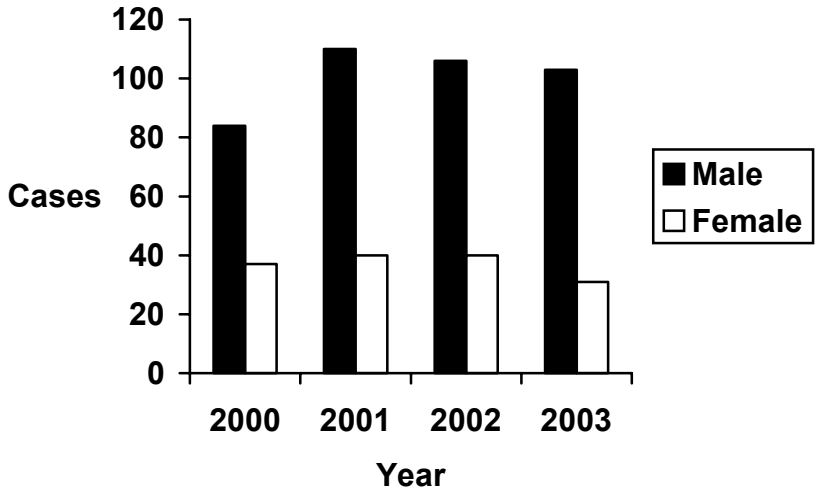
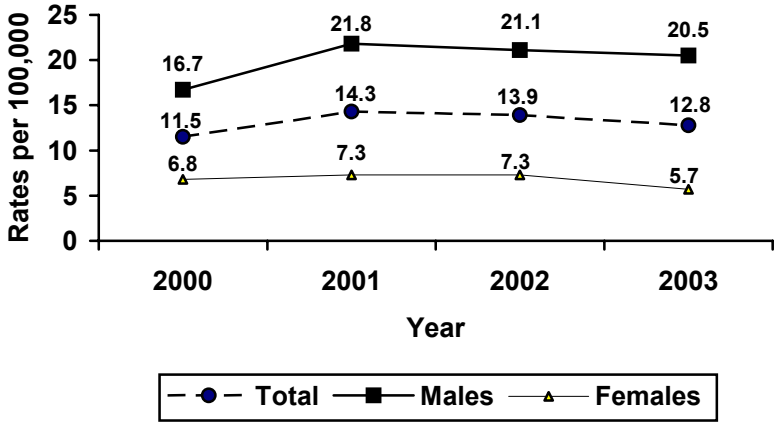


Figure 13. Rhode Island Reported HIV Cases per 100,000 Population, 2000-2003



Rates are based on the 2000 RI population as calculated by the U.S. Census Bureau

The mode of exposure and demographic characteristics of those infected with HIV differ significantly between both genders. Tables 6 and 7 illustrate these differences among males and females respectively.

Table 6. Demographic Characteristics of Male HIV Cases, January 1, 2000, to December 31, 2003.

Demographic Characteristics	Number of Newly Diagnosed Cases of HIV				
	2000	2001	2002	2003	Total
Age Group					
<13	<5 *	<5 *	<5 *	<5 *	<5 *
13-19	<5 *	<5 *	<5 *	<5 *	9 (2.2%)
20-29	13 (15.5%)	20 (18.2%)	27 (25.5%)	18 (17.5%)	78 (19.4%)
30-39	36 (42.9%)	42 (38.2%)	40 (37.7%)	43 (41.7%)	161 (40.0%)
40-49	27 (32.1%)	36 (32.7%)	28 (26.4%)	26 (25.2%)	117 (29.0%)
50+	7 (8.3%)	9 (8.2%)	7 (6.6%)	15 (14.6%)	38 (9.4%)
Total	84 (100%)	114 (100%)	106 (100%)	103 (100%)	304 (100%)
Race/Ethnicity					
White	33 (39.3%)	44 (40.0%)	51 (48.1%)	37 (35.9%)	165 (40.9%)
Black	20 (23.8%)	32 (29.1%)	37 (34.9%)	33 (32.0%)	122 (30.3%)
Hispanic	26 (31%)	33 (30.0%)	18 (17.0%)	30 (29.1%)	107 (26.6%)
Asian/Pac Islander	5 (6.0%)	<5 *	<5 *	<5 *	8 (2.0%)
Native American	<5 *	<5 *	<5 *	<5 *	<5 *

Total	84 (100%)	110(100%)	106 (100%)	103 (100%)	403 (100%)
Risk Factor					
MSM	28 (33.3%)	48 (43.6)	43 (40.6%)	45 (43.7%)	164 (40.7%)
IDU	17 (20.2%)	19 (17.3%)	16 (15.1%)	9 (8.7%)	61 (15.1%)
MSM / IDU	<5 *	<5 *	<5 *	5 (4.9%)	9 (2.2%)
Heterosexual Contact	10 (11.9%)	13 (11.8%)	11 (10.4%)	12 (11.7%)	46 (11.4%)
Transfusion	<5 *	<5 *	<5 *	<5 *	<5 *
No Risk Specified	27 (32.1%)	28 (25.5%)	36 (34.0%)	31 (30.1%)	122 (30.3%)
Total	84 (100%)	110 (100%)	106 (100%)	103 (100%)	403 (100%)
* Cell contained less than five cases					

Table 7. Demographic Characteristics of Female HIV Cases, January 1, 2000, to December 31, 2003.

Demographic Characteristics	Number of Newly Diagnosed Cases of HIV				
	2000	2001	2002	2003	Total
Age Group					
<13	<5 *	<5 *	<5 *	<5 *	<5 *
13-19	<5 *	<5 *	<5 *	<5 *	8 (5.4%)
20-29	12 (32.4%)	12 (30.0%)	9 (22.5%)	10 (32.3%)	43 (29.1%)
30-39	19 (51.4%)	17 (42.5%)	18 (45%)	10 (32.3%)	64 (43.2%)
40-49	*	6 (15.0%)	11 (27.5%)	6 (19.4%)	27 (18.2%)
50+	*	*	*	*	6 (4.1%)
Total	37 (100%)	40 (100%)	40 (100%)	31 (100%)	148 (100%)
Race/Ethnicity					
White	8 (21.6%)	10 (25.0%)	13 (32.5%)	6 (19.4%)	37 (25.0%)
Black	18 (48.6%)	18 (45.0%)	14 (35.0%)	15 (48.4%)	65 (43.9%)
Hispanic	11 (29.7%)	12 (30.0%)	13 (32.5%)	10 (21.7%)	46 (31.1%)
Asian/Pacific Islander	<5 *	<5 *	<5 *	<5 *	<5 *

Native American	<5 *	<5 *	<5 *	<5 *	<5 *
Total	37 (100%)	40 (100%)	40 (100%)	31 (100%)	148 (100%)
Risk Factor					
IDU	8 (21.6%)	8 (20.0%)	8 (20.0%)	*	28 (18.9%)
Heterosexual Contact	13 (35.1%)	16 (40.0%)	9 (22.5%)	13 (41.9%)	51 (34.5%)
Transfusion	<5 *	<5 *	<5 *	<5 *	<5 *
No Risk Specified	16 (43.2%)	15 (34.5%)	21 (52.5%)	13 (41.9%)	65 (43.9%)
Total	37 (100%)	40 (100%)	40 (100%)	31 (100%)	148 (100%)
* Cell contained less than five cases					

HIV in Rhode Island:
Highlights

Of the 551 HIV cases diagnosed and reported to the Rhode Island Department of Health from January 1, 2000, through December 31, 2003:

- Males accounted for 77% of the cases and females accounted for 23%.
- The majority of cases were between the ages of 30 and 39.
- The majority of cases (87%) were residents of Providence County.

Race/ethnicity

- Whites accounted for the majority of cases among men (41%), followed by African Americans (30%) and Hispanics (27%).

- African Americans accounted for the majority of cases among women (44%), followed by Hispanics (31%) and Whites (25%).

Mode of exposure

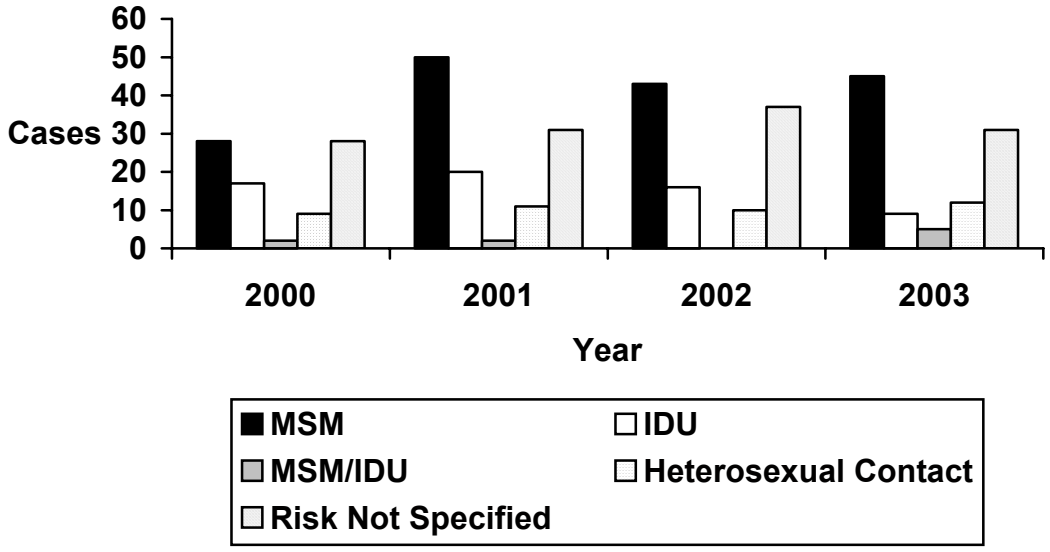
- MSM is the leading mode of exposure among men (41% of cases), followed by No Risk Specified (30%).
- No Risk Specified is the leading mode of exposure among women (44% of cases), followed by Heterosexual Contact (35%).

(3) Who is experiencing differential impact from the HIV/AIDS epidemic?

MSM (Men Who Have Sex With Men)

Despite an overall decrease in the rates of HIV and AIDS incidence, MSM continues to be the leading exposure category for HIV infection among men. Figure 10 illustrates this finding over the period from January 1, 2000 to December 31, 2003. The second highest exposure category is Risk Not Specified. Whether this represents a true lack of knowledge as to how these individuals were infected or a reluctance to reveal an MSM orientation or any other risk factor requires further investigation. Figure 10 illustrates these finding over the period from January 1, 2000 to December 31, 2003.

Figure 14. HIV (not AIDS) Incidence Among Men by Exposure Category 2000-2003.



As for the racial distribution of HIV infection among the MSM population, Whites account for the vast majority of MSM infected with HIV 61%, compared to 22% for African

Americans and 16% for Hispanics. HIV disproportionately affects African American and Hispanic MSMs; they represent 14% of Rhode Island's population and account for 38% of the MSM infected with HIV. Looking at the rates per 100,000 illustrates a much clearer picture. Figures 14 and 15, illustrate these findings in the period from January 1, 2000 to December 31, 2003.

Figure 15. HIV Infected MSM by Race, 2000-2003

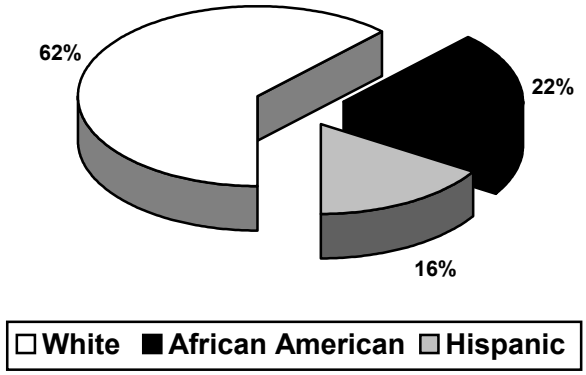
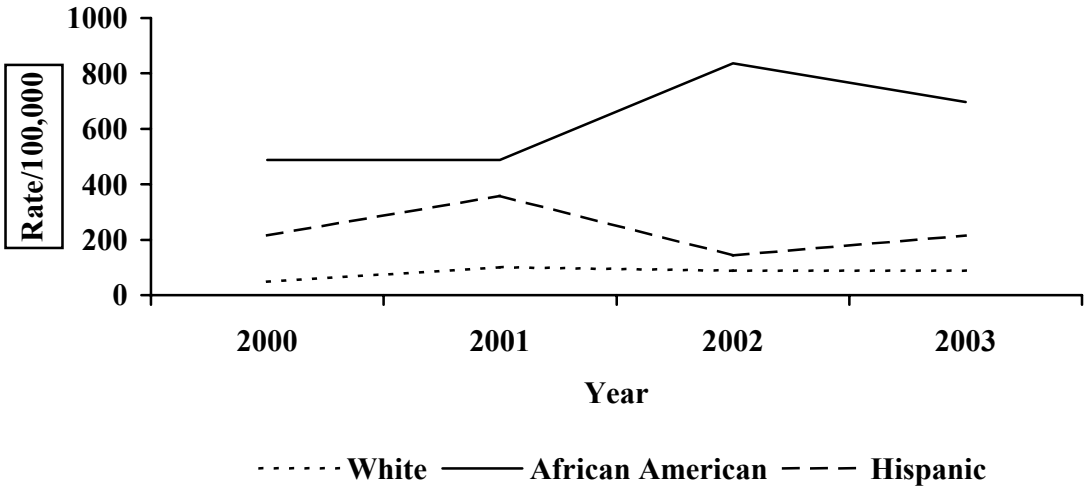


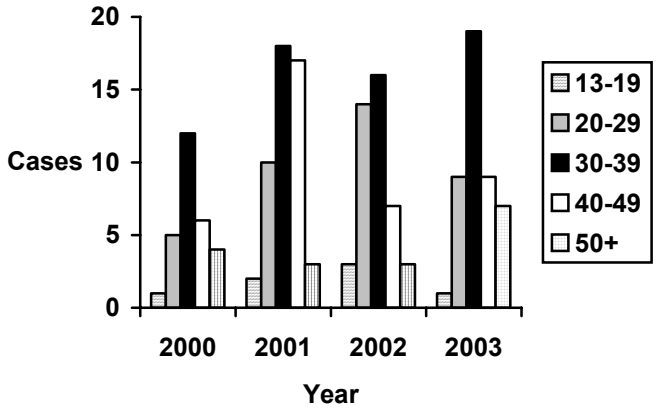
Figure 16. HIV Rates Among MSMs by Race, 2000-2003*



**This graph was made with the assumption that MSMs make up about 9% of the adult male population 13 years of age and older in Rhode Island. Rates are based on the 2000 RI population as calculated by the U.S. Census Bureau*

The age distribution of MSM infected with HIV, from January 1, 2000 to December 31, 2003, follows a similar pattern to the overall individuals infected with HIV, with the majority between 30 – 39 years of age.

Figure 17. HIV Infected MSM by Age and Year of Diagnosis



IDU (Intravenous Drug Users)

While Intravenous Drug Use remains a significant risk factor for HIV infection, there has been a steady decline in both HIV (not AIDS) and AIDS cases associated with IDU. HIV infection due to intravenous drug use dropped from 50% in 1989 to 10% in 2003. The decline in both AIDS and HIV cases associated with IDU follows a national trend.

We believe that a myriad of factors contributed to this decline, education among IDUs on safer needle use practices, availability of clean needles and needle cleaning kits through needle exchange programs, the availability of non-prescription needle sales at pharmacies and a general shift away from parenteral drugs among elicit drug users in the past years.

Rhode Island is one of the states that have a Needle Exchange Program; the Rhode Island Needle Exchange Program was launched in 1995. The Syringe Repeal Act was passed in Rhode Island in 2002, which allows individuals to purchase needles at pharmacies without the need of a prescription. The following chart shows the decline in HIV cases due to IDU in the period from 1989-2003.

Figure 18. Percentage of HIV Cases with IDU as their Identified Mode of Transmission

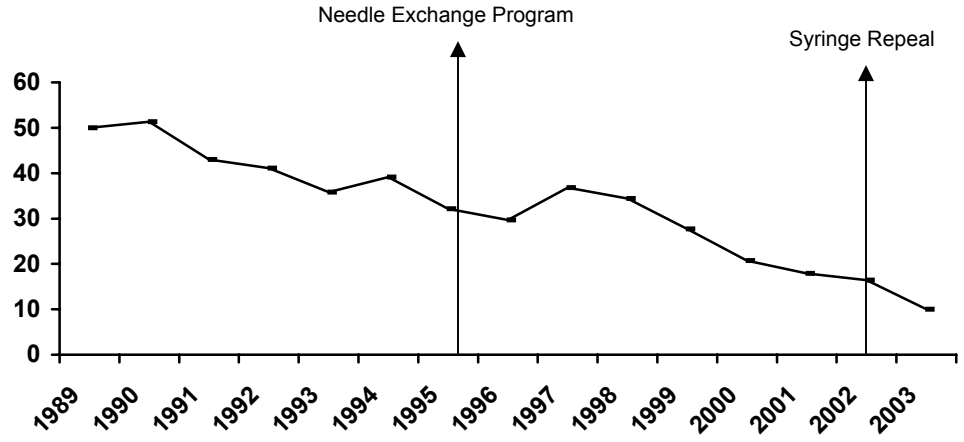
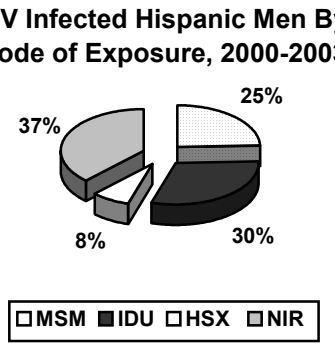


Figure 19. Percentage of HIV Infected Hispanic Men and Women Who Acquired Infection Through IDU 2000-2003. This indicates that 30% of HIV infected Hispanic men and 24% of HIV infected Hispanic women acquired their infection through IDU in the period from 2000-2003.



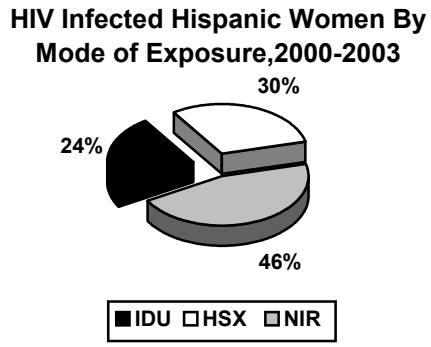
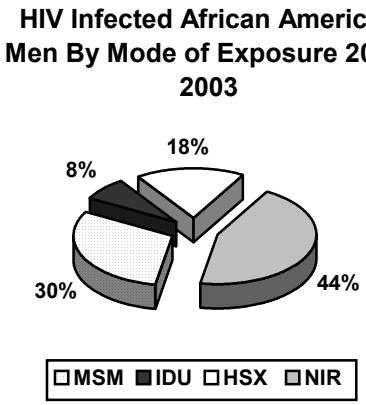


Figure 20. Percentage of HIV Infected African-American Men and Women Who Acquired Infection Through IDU 2000-2003. This indicates that 7% of HIV infected African American men and 9% of HIV infected African American women acquired their infection through IDU.



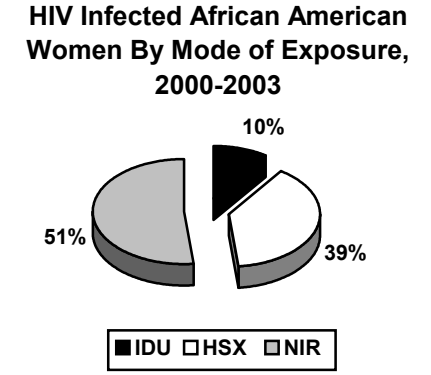
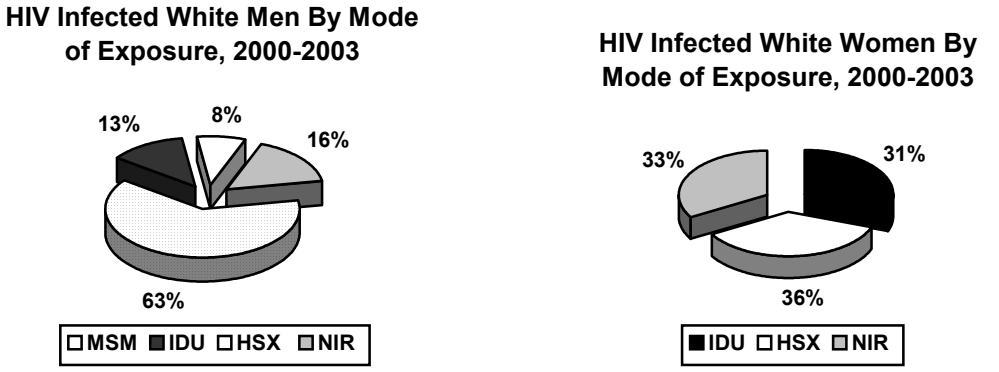


Figure 21 Percentage of HIV Infected White Men and Women Who Acquired Infection Through IDU 2000-2003. This indicates that 12% of HIV infected White men and 30% of HIV infected White women acquired their infection through IDU in the period from 2000-2003.



While IDU remains a major risk factor for HIV for both men and women, a greater proportion of women are infected with HIV through IDU. Among Rhode Island women, a greater proportion of minority women (African American and Hispanic) are infected through IDU when compared with their white counterparts. Tables 8 and 9 show the demographic characteristics of the HIV infected men and women with IDU as their mode of exposure.

Table 8. Demographic Characteristics of HIV Infected Male IDU by Year of Diagnosis

	2000	2001	2002	2003	Total
Race					
White	7(41.2%)	<5 *	9 (56.3%)	<5 *	20 (32.8%)
Black	<5 *	<5 *	<5 *	<5 *	9 (14.8%)
Hispanic	8(47.1%)	13 (68.4%)	<5 *	7 (77.8%)	32 (52.5%)
Asian/Pac Islander	<5 *	<5 *	<5 *	<5 *	<5 *
Native American	<5 *	<5 *	<5 *	<5 *	<5 *
Total	17 (100%)	19 (100%)	16 (100%)	9 (100%)	61 (100%)

Age Group					
13-19	<5 *	<5 *	<5 *	<5 *	<5 *
20-29	<5 *	<5 *	<5 *	<5 *	6 (9.8%)
30-39	5 (29.4%)	6 (31.6%)	<5 *	5 (55.6%)	20 (32.8%)
40-49	11 (64.7%)	7 (36.8%)	8 (50.0%)	<5 *	29 (47.5%)
50+	<5 *	<5 *	<5 *	<5 *	6 (9.8%)
Total	17 (100%)	19 (100%)	16 (100%)	9 (100%)	61 (100%)

Table 9. Demographic Characteristics of HIV Infected Female IDU by Year of Diagnosis

	2000	2001	2002	2003	Total
Race					
White	<5 *	<5 *	<5 *	<5 *	11 (39.3%)
Black	<5 *	<5 *	<5 *	<5 *	6 (21.4%)
Hispanic	<5 *	<5 *	5 (62.5%)	<5 *	11 (39.3%)
Asian/Pac Islander	<5 *	<5 *	<5 *	<5 *	<5 *
Native American	<5 *	<5 *	<5 *	<5 *	<5 *
Total	8 (100%)	8 (100%)	8 (100%)	4 (100%)	28 (100%)
Age Group					
13-19	<5 *	<5 *	<5 *	<5 *	<5 *
20-29	<5 *	<5 *	<5 *	<5 *	6 (21.4%)
30-39	6 (75.0%)	<5 *	5 (62.5%)	<5 *	16 (57.1%)
40-49	<5 *	<5 *	<5 *	<5 *	6 (21.4%)
50+	<5 *	<5 *	<5 *	<5 *	<5 *
Total	8 (100%)	8 (100%)	8 (100%)	4 (100%)	28 (100%)

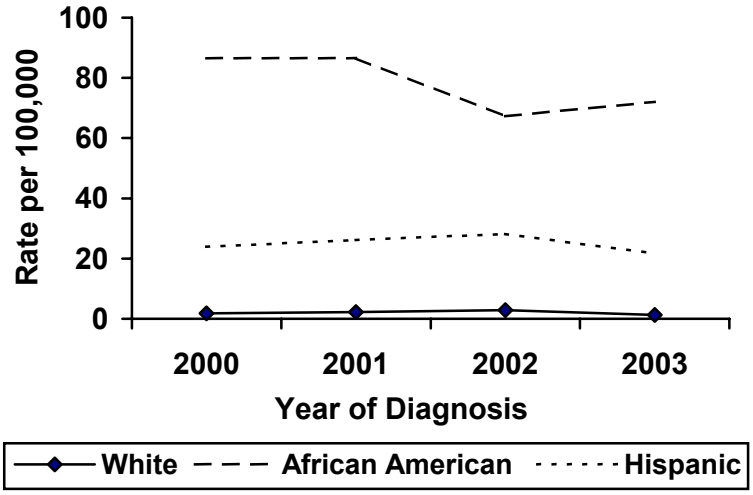
Minority Women

In the period between January 1, 2000 to December 31, 2003, 148 women were diagnosed with HIV (not AIDS) in Rhode Island. African American and Hispanic women who represent 14% of Rhode Island's female population accounted for 75% of those cases. The impact of HIV on African American and Hispanic women far exceeds that on African American and Hispanic men who account for 57% of all men diagnosed with HIV during the same time period.

While African Americans and Hispanics of both genders are disproportionately affected by the epidemic the impact on women is tremendous. Figure 21 best illustrates the

disproportionate impact of HIV on minority women as it shows the rate of HIV infection by race per 100,000 women.

Figure 22. HIV Rates Among Women by Race/Ethnicity, Rhode Island, January 1, 2000-December 31, 2003

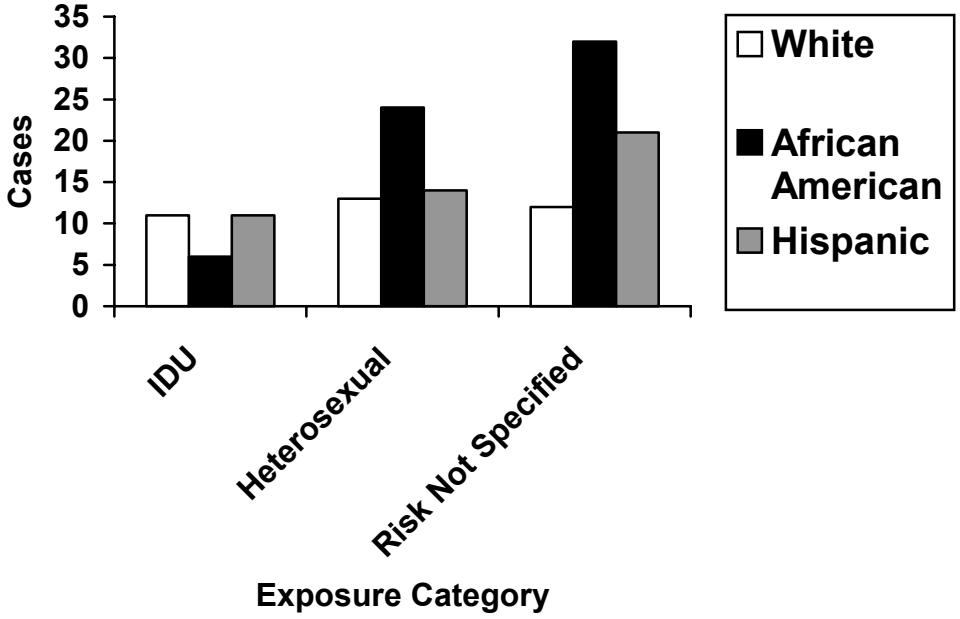


Rates are per 100,000 population. Rates are based on 2000 RI population as calculated by the U.S. Census Bureau.

As for the exposure category, Hispanic women have the highest number of cases with IDU as their mode of exposure to HIV, while African American and White women have an equal number of cases with heterosexual contact as their mode of exposure to HIV.

It is worth mentioning that a large proportion of African American and Hispanic women have an unspecified risk of exposure. Whether this represents a true lack of knowledge as to how they were infected or not, requires further investigation. Figure 22 illustrates the aforementioned findings.

Figure 23. HIV Rates Among Women by Exposure Category, Rhode Island, January 1, 2000-December 31, 2003



Inmates of the Rhode Island ACI (Adult Correctional Institution)

Prison inmates accounted for 26 percent of newly diagnosed HIV cases (31 of 121 cases) in 2000, 21 percent (31 of 150 cases) in 2001, 19 percent (28 of 146 cases) in 2002 and 22 percent (29 of 134 cases) in 2003. The demographic characteristics of prison inmates newly diagnosed with HIV were similar in all 3 years. Most cases of HIV were diagnosed among persons between the ages of 30 and 39 and most were males. Among prison inmates newly diagnosed with HIV, Hispanics had the most cases, followed by African Americans, then Whites. Risk Not Specified and IDU were more commonly associated with HIV infection among prison inmates than other risk factors.

Table 10. Percentage of newly diagnosed cases of HIV, RI prison inmates, January 1, 2000 -December 31, 2003, by demographic characteristics

	2000	2001	2002	2003	Total
Gender					
Male	27 (87%)	27 (87%)	24 (86%)	24 (83%)	102 (86%)
Female	<5 *	<5 *	<5 *	5 (27%)	17 (14%)
Total	31 (100%)	31 (100%)	28 (100%)	29 (100%)	119 (100%)
Race					
White	8 (26%)	<5 *	11 (39%)	<5 *	27 (23%)
Black	10 (32%)	12 (39%)	10 (36%)	13 (45%)	45 (38%)
Hispanic	11 (36%)	15 (48%)	7 (25%)	11 (38%)	44 (37%)
Asian/Pacific Islander	<5 *	<5 *	<5 *	<5 *	<5 *
Native American/Alaska Native	<5 *	<5 *	<5 *	<5 *	<5 *
Total	31 (100%)	31 (100%)	28 (100%)	29 (100%)	119 (100%)
Age Group					
13-19	<5 *	<5 *	<5 *	<5 *	<5 *
20-29	6 (19%)	7 (23%)	5 (18%)	5 (17%)	23 (19%)
30-39	15 (48%)	17 (55%)	12 (43%)	15 (52%)	59 (47%)
40-49	7 (23%)	7 (23%)	11 (39%)	8 (28%)	33 (28%)
50+	<5 *	<5 *	<5 *	<5 *	<5 *
Total	31 (100%)	31 (100%)	28 (100%)	29 (100%)	546 (100%)
MSM	<5 *	<5 *	<5 *	<5 *	11 (9%)
IDU	6 (19%)	9 (29%)	6 (21%)	6 (22%)	27 (23%)
MSM/IDU	<5 *	<5 *	<5 *	<5 *	<5 *
Heterosexual Contact	<5 *	<5 *	<5 *	<5 *	5 (4%)
Hemophilia	<5 *	<5 *	<5 *	<5 *	<5 *
No Risk Specified	18 (58%)	17 (55%)	18 (64%)	20 (69%)	73 (61%)
Total	31 (100%)	31 (100%)	28 (100%)	29 (100%)	119 (100%)
* Cell contained less than five cases					

Persons Unaware of Their HIV Status

The Centers for Disease Control and Prevention (CDC) estimates that 25% of those infected with HIV are unaware of their status. Those individuals do not seek medical treatment and hence are unable to experience the overall improvement in quality of life, experienced by other HIV infected individuals, owed to improvement in health services and advances in treatment modalities. Furthermore they do not receive any education on behavioral risk reduction and therefore continue to be a potential source for HIV transmission.

Individuals who became aware of their positive HIV status when diagnosed with AIDS are individuals that were unaware of their infection for the most part and were diagnosed late in the course of their infection. Thus, they are representative of those that are infected but unaware of their status.

133 individuals become aware of their positive HIV status when diagnosed with AIDS in the period from 2000-2003, which is approximately 24% of the 551 individuals diagnosed with HIV in the same time period.

30% of the individuals who became aware of their HIV status when diagnosed with AIDS were females, 70% were males. The majority of those who become aware of their HIV status when diagnosed with AIDS were Whites 36%(who represent 82% of the population), followed by African Americans 34% (who represent 5% of the population), and Hispanics 28%(who represent 9% of the population). African Americans and Hispanics make up the vast majority of those who become aware of their HIV status when diagnosed with AIDS. The number one risk factor among those who become aware of their HIV status when diagnosed with AIDS is heterosexual contact (50%), followed by MSM (26%) and IDU (22%).

Table 11 provides a comparison of demographic characteristics among those who become aware of their positive HIV status when diagnosed with AIDS and those diagnosed with HIV alone.

Table 11. Comparison of the Demographic Characteristics of Individuals Diagnosed with HIV Only and Individuals Who Become Aware of Their Positive HIV Status When Diagnosed with AIDS, January 1, 2000 to December 31, 2003.

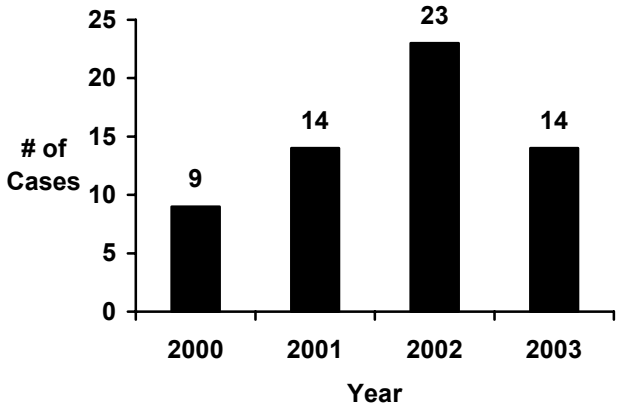
Demographic Characteristics	Individuals Diagnosed with HIV (only), 2000-2003	Individuals Diagnosed with HIV and AIDS, 2000-2003
Gender		
Male	403 (73.1%)	93 (70%)
Female	148(26.9%)	40 (30%)
Total	551 (100%)	133 (100%)
Age Group		
<13	<5 *	<5 *
13-19	17 (3.1%)	<5 *
20-29	121 (22.0%)	15 (11%)
30-39	225 (40.8%)	51 (38%)
40-49	144 (26.1%)	51 (38%)
50+	44 (8.0%)	12 (9%)
Total	551 (100%)	133 (100%)
Race/Ethnicity		
White	202 (36.7%)	48 (36%)
Black	187 (33.9%)	45 (34%)
Hispanic	153 (27.8%)	37 (28%)
Asian	8 (1.5%)	<5 *
Native American	<5 *	<5 *
Total	551 (100%)	133 (100%)
Risk Factor		
MSM	164 (29.8%)	33 (26%)
IDU	89 (16.2%)	28 (22%)
MSM / IDU	9 (1.6%)	<5 *
Heterosexual Contact	97 (17.6%)	64 (50%)
Transfusion	<5 *	<5 *
No Risk Specified	187 (33.9%)	<5 *
Total	551 (100%)	133 (100%)
* Cell contained less than five cases		

Youth

In the United States, HIV-related death has the greatest impact on young and middle-aged adults, particularly racial and ethnic minorities. In 1999, HIV was the fifth leading cause of death for Americans between the ages of 25-44. Among African American men in this age group, HIV has been the leading cause of death since 1991. In 1999, among black women 25-44 years old, HIV infection was the third leading cause of death. Many of these young adults likely were infected in their teens and twenties. It has been estimated that at least half of all new HIV infections in the United States are among people under 25, the majority of young people are infected sexually (Rosenberg PS, Biggar RJ, Goedert JJ. Declining age at HIV infection in the United States [letter]. *New Engl J Med* 1994; 330:789-90)

Eleven percent (60 out of 551) of all the HIV cases diagnosed in Rhode Island in the period from January 1, 2000 to December 31, 2002 occurred in individuals 14 – 24 years of age. There has been a steady rise in the incidence of HIV among this age group in the past three years. Figure 23 illustrates these findings.

Figure 24. HIV Incidence among Youth (14-24 years old), January 1, 2000 to December 31, 2003.



Of the 60 cases diagnosed among youth 36 were males and 24 were females. Youth of racial and ethnic minorities were heavily impacted with 40% (24 cases) occurring in African American youth, 33% (20 cases) occurring in Hispanic youth and 27% (16 cases) occurring in White youth.

Among males, Male-to-Male Sex (50%) was the most common risk category followed by Unspecified Risk (36%). Among females Unspecified Risk (54%) was the most common risk category followed by Heterosexual Contact (38%). Figures 24 and 25 illustrate these findings.

Figure 25. HIV Rates Among Male Youth by Exposure Category, Rhode Island, 2000-2003

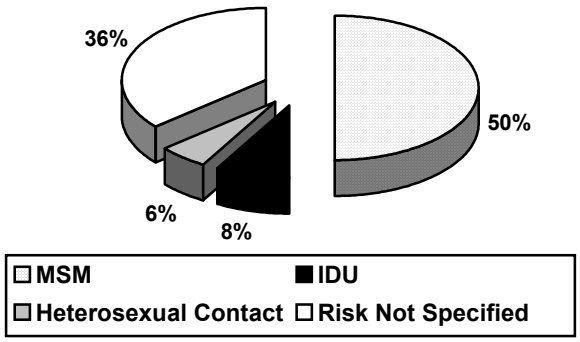
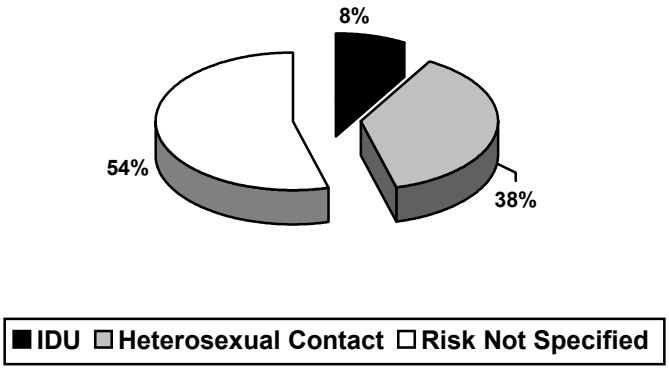


Figure 26. HIV Rates Among Female Youth by Exposure Category, Rhode Island, 2000-2003



Appendix:
Surrogate Data in Rhode Island

STD Trends in Rhode Island: 2002 vs. 2003

In 2003, reports of gonorrhea and chlamydia increased significantly over 2002. A comparison of reported cases of gonorrhea and chlamydia between 2002 and 2003 is provided in Table 1. Reports of early syphilis included thirty-three primary and secondary syphilis cases and seven early latent cases in 2003. Late syphilis reports increased from forty-five reported cases in 2002 to fifty cases for 2003.

Table 1. Trends in STDs in Rhode Island: 2002 VS 2003

	Chlamydia			Gonorrhea		
	2002	**2003**	**% Change***	**2002**	**2003**	**% Change***
Total # of Cases	**2,832**	3,000	**5.6**	**900**	**973**	**8.1**
Sex						
Male	**775**	768	**-0.9**	**416**	456	**9.6**
Female	**2057**	2,232	**8.5**	**484**	517	**6.8**
Race/Ethnicity*						
Non-Hispanic White	**1,072**	876	**--**	**308**	346	**--**
Non-Hispanic Black	**648**	619	**--**	**373**	323	**--**
Hispanic	**960**	804	**--**	**185**	196	**--**
Asian/PI	**93**	87	**--**	**5**	9	**--**
American Indian	**26**	12	**--**	**11**	9	**--**
Other/Unknown	**33**	602	**--**	**18**	90	**--**
Age						
<10	**<5**	<5	**--**	**0**	<5	**--**
10-14	**43**	37	**-14.0**	**17**	12	**-29.4**
15-19	**904**	941	**4.1**	**243**	277	**14.0**
20-24	**1,107**	1,150	**3.9**	**287**	269	**-6.3**
25-29	**432**	456	**5.6**	**172**	148	**-14.0**
30-34	**174**	206	**18.4**	**76**	95	**25.0**
35-39	**89**	111	**24.7**	**44**	86	**95.5**
40-44	**43**	49	**14.0**	**37**	43	**16.2**
45-54	**30**	28	**-6.7**	**20**	26	**30.0**
55-64	**6**	7	**16.7**	**<5**	9	**200.0**
65+	**<5**	<5	**--**	**0**	<5	**--**
Unknown	**<5**	8	**--**	**1**	4	**--**

The %change for race/ethnicity for both Chlamydia and gonorrhea cases cannot be calculated due to the large percentage of cases missing data for those diseases.

Syphilis

Rhode Island, like many other parts of the country, has seen an increase in the reports of infectious syphilis. Although the increase in numbers is not as dramatic as other regions of the country, it is still significant nonetheless. There were forty cases of infectious syphilis statewide in 2003, an increase of 72% over the twenty-two reported cases in 2002. Perhaps more striking is the 700% increase in infectious syphilis from 2000 to 2003. Twenty-nine of

the forty reported cases were male and nineteen of those twenty-nine cases (66%) were men who have sex with men. Of the latter, twelve were self-reported to be HIV positive (63% of the MSMs with infectious syphilis). Unlike gonorrhea and Chlamydia, where infection is distributed mostly among the 15-24 year old population, the cases of infectious syphilis reported in Rhode Island had an average age of 37 years old. This is an increase from last year when the average age of those infected with infectious syphilis was 34 years old. Table 2 provides a brief overview of infectious syphilis in Rhode Island from 2000 to 2003.

Table 2. *Infectious Syphilis Cases, Rhode Island, 2000 – 2003*

	2000		***2001***		***2002***		***2003***	
	#	***Rate****	***#***	***Rate****	***#***	***Rate****	***#***	***Rate****
Statewide	5	0.5	12	1.1	22	2.2	40	3.8
Core Cities (Providence, Pawtucket, Central Falls)	2	0.8	9	3.4	16	6.0	21	7.9
Hispanic	1	1.1	0	0	8	8.8	3	3.3
Black	3	7.2	2	4.8	2	4.8	7	16.7
White	1	0.1	10	1.2	12	1.4	27	3.1

** Rates are expressed as cases/100,000 population. Rates are based on the 2000 Rhode Island population as calculated by the U.S. Bureau of the Census.*

Gonorrhea

The year 2003 marked the fifth year in a row that the number of gonorrhea case in Rhode Island arose. There were 973 cases of gonorrhea reported in 2003 compared to 900 cases in 2002. This corresponds to an 8.1% increase in the number of cases reported to the Department of Health from 2002 to 2003. There has been a 126% increase in the reported cases of gonorrhea from 1998, when only 430 cases were reported, to 2003. The statewide incidence of gonorrhea rose from 86 cases per 100,000 in 2002 to 93 cases per 100,000 in 2003.

Unfortunately in 2003, nine percent of the race/ethnicity data was missing on the reported cases of gonorrhea. Although there was a large percentage of data missing for race/ethnicity in 2003, the Department of Health doesn't believe that the providers who failed to report race/ethnicity on gonorrhea cases saw a different population then those providers who did report race/ethnicity. If this holds true, then the percentages of race/ethnicity can be compared from year to year for those cases that the Department of Health does have race/ethnicity data. With that in mind, the highest percentage of cases was seen in non-Hispanic whites (39.2%). This was different than other years, when the non-Hispanic blacks had the highest percentage of gonorrhea cases. When comparing 2002 to 2003, the non-Hispanic whites were the only ethnic/racial group to have an increase in the percentage of cases. Non-Hispanic blacks saw a decrease from 41.4% in 2002 to 36.6% in 2003. Hispanics remained for the most part stable in 2003 at 22.2%.

Reported cases of gonorrhea were concentrated in Providence County where 864 residents (88.8%) were reported to be infected. The City of Providence reported 517 cases of gonorrhea (53.1%) in 2003. The number of non-Hispanic whites infected in the City of Providence was estimated to have increased 29.4% from 2002 to 2003 while number of reported non-Hispanic blacks infected was estimated to have increased 20.7%. Only the number of reported Hispanics infected remained for the most part stable, with an estimated increase of only 1.6%. This was the second year in a row where the Hispanic population remained stable.

Five hundred seventeen cases (53%) of gonorrhea were reported in females and four hundred fifty-six cases (47%) in males in 2003. When comparing 2002 to 2003, the number of reported cases of gonorrhea in males increased almost 10%, while the number of cases in females increased nearly 7%. More than half of the cases (56%) were in their late teens and early twenties. A little more than eight of ten reported cases (82%) were less than 35 years of age. This percentage is lower than in previous years, when approximately 90% of the reported gonorrhea cases were less than 35 years of age.

With the recent outbreak of syphilis in Rhode Island and the awareness of the high risk sexual behavior that may be occurring within its borders, the Department of Health has taken a closer look at the epidemiology of gonorrhea in Rhode Island and in particular, the male: female ratio of gonorrhea cases within age groups. As noted above, the average age of cases of infectious syphilis is much higher than that of gonorrhea. The hypothesis is that with the increased high-risk sexual behavior in the older MSM male population of Rhode Island, the male: female case ratio may change when compared to previous years. For the most part, the ratios have not changed significantly. With that said, 2003 saw an increase in the male: female ratios in the age groups between 40 – 64 years old. This increase was especially seen in the age groups between 45- 64 years old. It is unknown at this time if this is an aberration or if this increase in the ratio is influenced by the high-risk behaviors of older males. This will continue to be followed.

Table 3. Male: Female Ratio for Reported Cases of Gonorrhea, Rhode Island, 2001-2003

	2001			2002			2003		
	Male	Female	Male: Female	Male	Female	Male: Female	Male	Female	Male: Female
15 – 19	79	183	0.4:1	71	172	0.4:1	81	196	0.4:1
20 – 24	114	163	0.7:1	136	151	0.9:1	118	151	0.8:1
25 – 29	64	74	0.9:1	85	87	1.0:1	74	74	1.0:1
30 – 34	43	32	1.3:1	50	26	1.9:1	58	37	1.6:1
35 – 39	27	12	2.3:1	33	11	3.0:1	57	29	2.0:1
40 – 44	8	6	1.3:1	25	12	2.1:1	31	12	2.6:1
45 – 54	<5	<5	2.0:1	13	7	1.9:1	24	<5	12.0:1
55 – 64	<5	0	3.0:0	<5	0	3.0:0	8	<5	8.0:1
65 +	0	0	--	0	0	--	<5	0	3.0:0

Chlamydia

Three thousand cases of chlamydia were reported in 2003, an increase of 5.6% when compared to the corresponding period in 2002. Two thousand two hundred thirty-two cases (74.4%) were female and seven hundred sixty-eight cases (25.6%) were male. Almost seventy percent of cases (69.7%) were reported in persons in the late teens and early twenties. Ninety-three percent of reported cases were less than thirty-five years of age.

About twenty percent of the race/ethnicity data was missing. This is because the Department of Health has ceased to send letters to medical providers to obtain surveillance case reporting forms from them regarding chlamydia infection. This action was in response to the large number of chlamydia infection in the state and also the decreased staff within the STD program. Although there was a large percentage of data missing for race/ethnicity in 2003 the Department of Health doesn't believe that the providers who failed to report race/ethnicity on chlamydia cases saw a different population then those who did report race/ethnicity. If this holds true, then the percentages of race/ethnicity can be compared from year to year for those cases that the Department of Health does have race/ethnicity data. Comparing 2002 to 2003 shows very little change in the distribution of chlamydia within race/ethnicity. The Hispanic population showed no change from 2002 to 2003 (33.9% in 2002 compared to 33.5% in 2003), while the black non-Hispanic (22.9% in 2002 compared to 25.8% in 2003) increased slightly. The white non-Hispanic population (37.8% in 2002 compared to 36.5% in 2003) slowed a slight decrease.

Reported cases of chlamydia were concentrated in Providence County, home to about half the population of Rhode Island, where 2,509 residents (83.6% of cases) were reported to be infected. One thousand three hundred thirty-four cases (44.5 %) were reported in residents of Providence.

ENCORE: Rhode Island's Needle Exchange Program

ENCORE (Education, Needle Exchange, Counseling, Outreach and Referral) is an anonymous and confidential program, conducted by the Office of HIV/AIDS in Rhode Island since April 1995. The purpose of the needle exchange program is to prevent HIV/AIDS by giving injection drug users the tools (such as new syringes, bleach, clean cotton, alcohol swabs, condoms, information on skin care, and counseling and/or referrals) to protect themselves. The information provided in the mandatory enrollment interview is helpful in identifying the risk behaviors of current IDUs in Rhode Island.

The following figures present number and demographic characteristics of the ENCORE enrollees.

Figure 27. New ENCORE Enrollments by Year

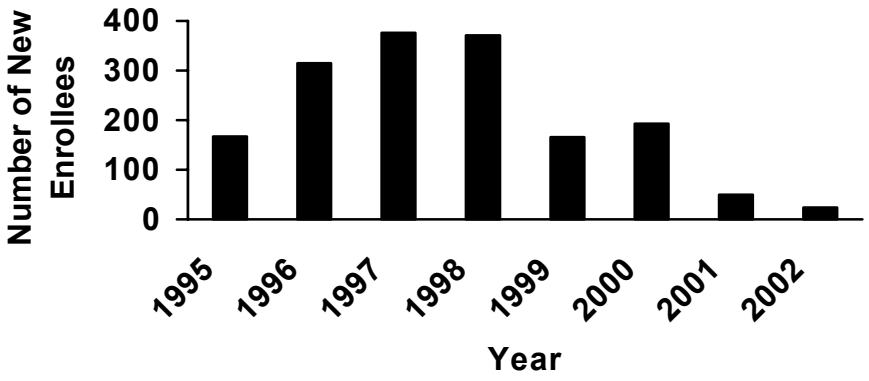


Figure 28. Gender Distribution of New ENCORE Enrollees 1995-2002

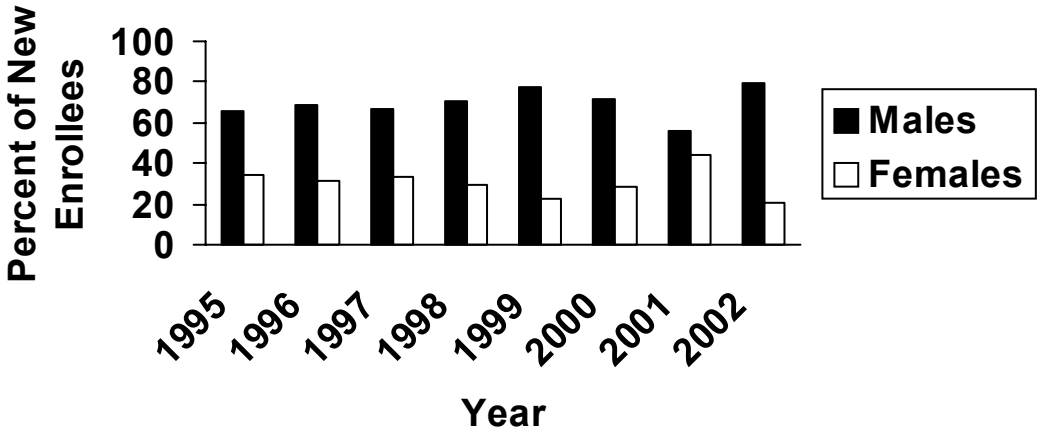


Figure 29. New ENCORE Enrollees by Race/Ethnicity 1995-2002

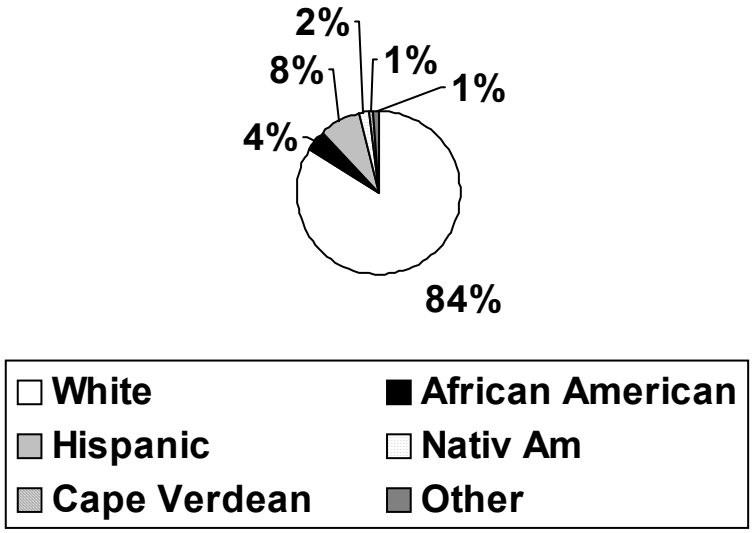
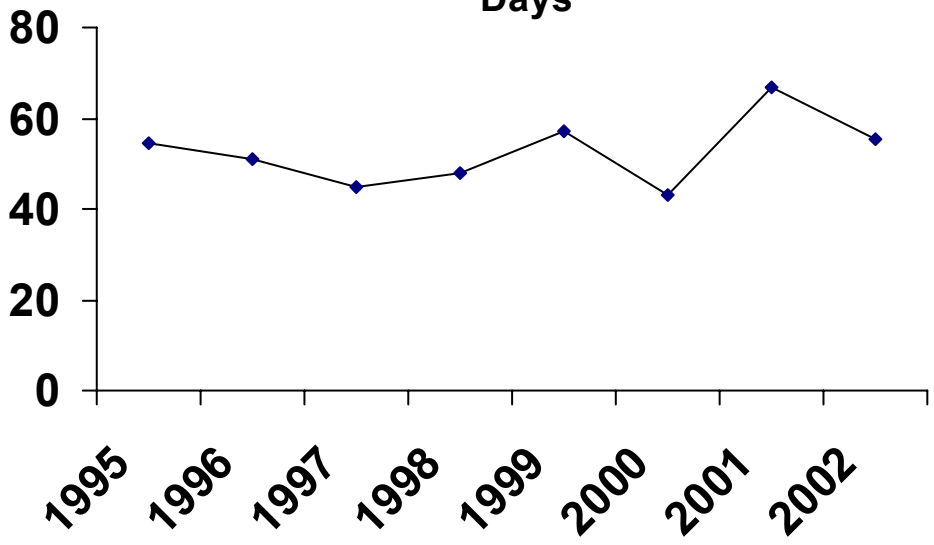


Figure 30. Percent of New Enrollees Who Have NOT Shared Syringes with Others in the Past 30 Days

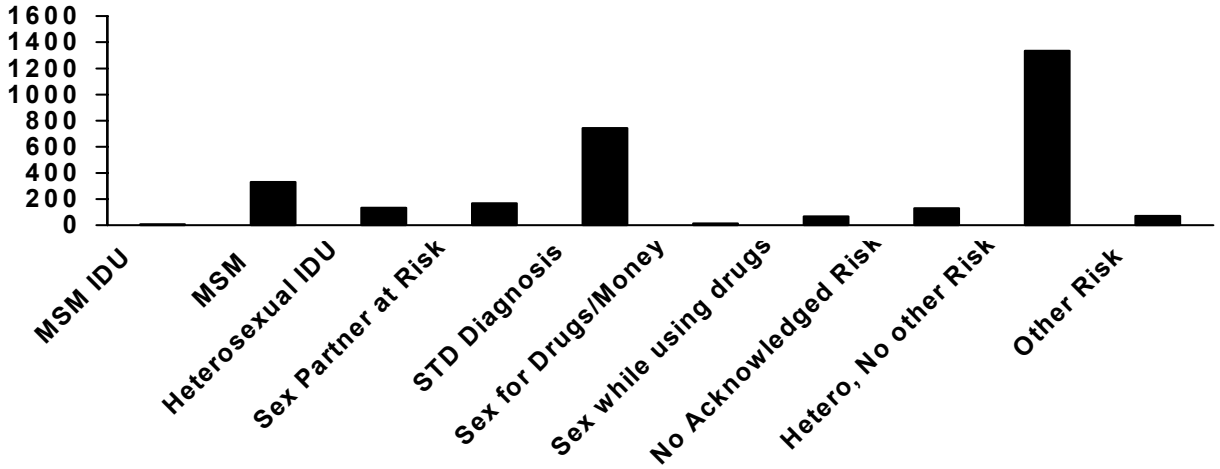


HIV Counseling Testing and Referral Sites in Rhode Island

Publicly funded counseling and testing services provided by State Health Department in collaboration with the CDC (Centers for Disease Control and Prevention) were initiated in 1985 to provide alternatives to blood donation as a means for high –risk persons to determine their HIV status. These services became an integral part of HIV prevention programs and the HIV Counseling and Testing System (CTS) was developed to monitor client's use of program services. CTS provide anonymous (no identifying information recorded) and confidential (identifying information recorded) voluntary HIV counseling, testing, and referral services.

In 2002 there were a total of 3,003 HIV tests performed at CTS in Rhode Island. Of these 3,003 tests 18 were positive. 722 tests were anonymous, 2,259 tests were confidential and 22 were unspecified. 2,040 (68%) of the individuals tested at CTS were males, 919 (31%) were females and 44 (1%) were of undetermined gender. 45% of those utilizing CTS services in 2002 were White, 24% were African American, 25% were Hispanic, 3% were Asian or Pacific Islander, 1% were native Americans, and 2% were of undetermined race. The majority of CTS clients were in the 20 to 29 years old age group (47%). Figure 18 illustrates the Distribution of clients by risk factors. We find in order of magnitude that heterosexuals were the largest group to utilize CTS services, followed by those with a previous STD diagnosis followed by MSM.

Figure 31. Distribution of CTS Clients by Risk Factor


1600
1400
1200
1000
800
600
400
200
0
MSM IDU
MSM
Heterosexual IDU
Sex Partner at Risk
STD Diagnosis
Sex for Drugs/Money
Sex while using drugs
No Acknowledged Risk
Hetero, No other Risk
Other Risk

Tuberculosis (TB) in Rhode Island

- Approximately 2 billion people (one-third of the world's population) are infected with *Mycobacterium tuberculosis*, the cause of TB.
- TB is the cause of death for one out of every three people with AIDS worldwide.
- The spread of the HIV epidemic has significantly impacted the TB epidemic - one-third of the increase in TB cases over the last five years can be attributed to the HIV epidemic (Source: UNAIDS).

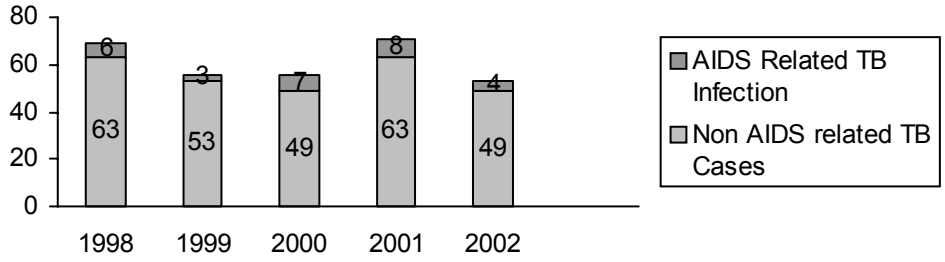
Tuberculosis (TB) is a disease that is spread from person-to-person through the air, and it is particularly dangerous for people infected with HIV. Worldwide, TB is the leading cause of death among people infected with HIV.

An estimated 10-15 million Americans are infected with TB bacteria, with the potential to develop active TB disease in the future. About 10 percent of these infected individuals will develop TB at some point in their lives. However, the risk of developing TB disease is much greater for those infected with HIV and living with AIDS. Because HIV infection so severely weakens the immune system, people dually infected with HIV and latent TB have a 100% lifetime probability of developing active TB disease and becoming infectious compared to people not infected with HIV. CDC estimates that 10 to 15 percent of all TB cases and nearly 30 percent of cases among people ages 25 to 44 are occurring in HIV-infected individuals.

This high level of risk underscores the critical need for targeted TB screening and preventive treatment programs for HIV-infected people and those at greatest risk for HIV infection. All people infected with HIV should be tested for TB, and, if infected, complete preventive therapy as soon as possible to prevent TB disease. (Source: http://www.cdc.gov/hiv/pubs/facts/hivtb.htm)

Rhode Island follows the national AIDS/TB co-infection trends. Approximately 10% of all TB infections diagnosed in the past five years were AIDS related. Figure 33, illustrates these findings.

Figure 32. AIDS/Non AIDS related TB Infections, 1998-2002



Viral Hepatitis C in Rhode Island

The national prevalence rate of hepatitis C was estimated at 1.8% in 1994; however, actual national prevalence is likely to be considerably higher. Low levels of public knowledge and understanding of HCV, and lack of programmatic funding for testing and referral resources even for the high risk, increase the likelihood that current prevalence rates are highly underestimated. Based on this estimate RI is likely to have as many as 16,000 prevalent cases of hepatitis C. This is a huge burden of disease, in recognition of which RI in 1998 launched a provider and public education campaign and started systematic surveillance to the extent feasible by limited resources.

The Department of Health has established a chronic hepatitis C registry in keeping with CDC guidance for the surveillance of hepatitis. The registry was in paper format from 1992 until an electronic database was created and populated in 1998. Positive laboratory reports are sent to the Department of Health. Information received from this component is recorded in an unduplicated registry of names, and serial test results are entered thus providing a record of all positive test results (preliminary and confirmatory).

Data obtained from laboratory reporting is subject to limitations. On some reports information is missing from certain fields. Also, this reporting system depends upon the cooperation and willingness of the laboratories to report, and it is therefore possible that underreporting occurs. Blood work ordered to labs from drug treatment facilities are without names and have codes instead, and often are lost to the system because of inadequate follow up for transcription. Duplicates are removed from the yearly positive report totals. A limited number of duplications may not be detectable if patients concerned about the sensitivity of the information use aliases. The data received also provides strongly limited information regarding race and ethnicity due to the high percentage of "unknown" entries in this field. Approximately 15% of individuals tested HCV positive will resolve and in the absence of serial viral load testing, and in the absence of an easy to perform antigen marker test, cannot be recognized as resolved cases, and remain in the registry. Another shortcoming is that until a second confirmatory test (such as RIBA or PCR) passively makes its way into the system cases remain unconfirmed, and may represent false positives.

Laboratory reports from the years 1992-2002 give an indication of trends during this time period. The number of positive reports increased significantly from 182 reports in 1992 to 1,821 reports in 2002. Increased provider and public knowledge regarding HCV can account for a significant percentage of this increase; however, this percentage cannot be determined. The increase may be due to the tendency of positive cases to be identified years after the exposure, and disease trends have suggested that the greatest number of new cases were contracted 10-30 years ago. The following charts show a basic overview of the number of positive lab reports in Rhode Island from 1992 to 2002.

Figure 33. Hepatitis C Lab Reports in RI by Year 1992-2002

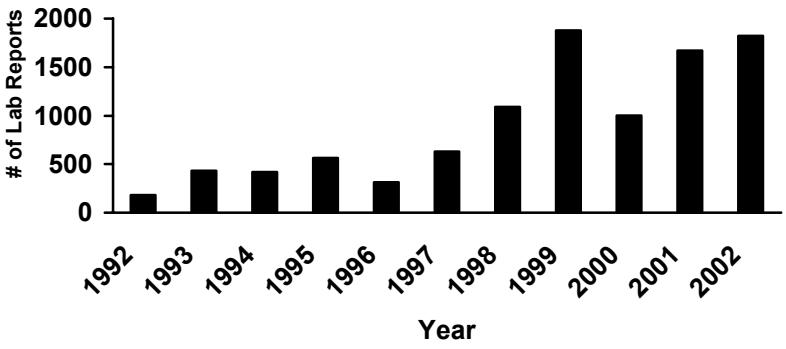


Figure 34. The Age Distribution of Individuals with Positive Hepatitis C Test Results 1992-2002

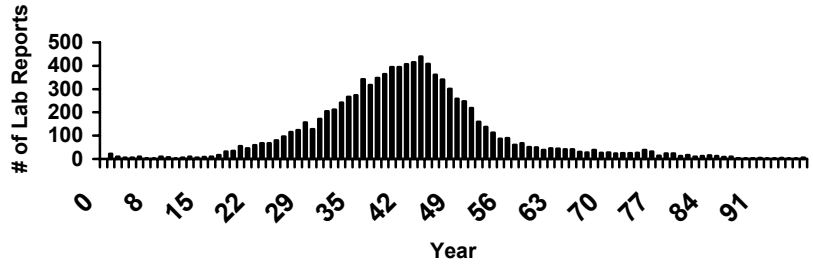
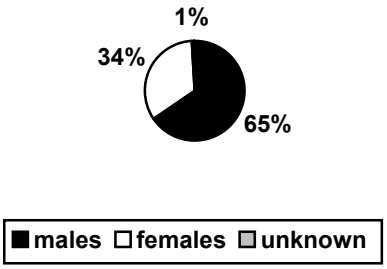


Figure 35. Gender Distribution of Positive HCV Lab Reports



About one quarter of HIV-infected persons in the United States are also infected with hepatitis C virus (HCV). HCV is one of the most important causes of chronic liver disease in the United States and HCV infection progresses more rapidly to liver damage in HIV-infected persons. HCV infection may also impact the course and management of HIV infection. (Source: http://www.cdc.gov/hiv/pubs/facts/HIV-HCV_Coinfection.htm.)

The Rhode Island Department of Health has responded over the course of the past few years to the high prevalence of hepatitis C, by systematic inclusion of hepatitis C prevention and control strategies in all HIV/AIDS related programming. Rhode Island's ENCORE program consists of education, needle exchange, counseling, outreach, and referrals. Because IDU is currently the most significant mode of HCV transmission, the ENCORE program captures a portion of the highest risk population. ENCORE was designed for and has traditionally focused on HIV and AIDS. However, HIV and HCV are transmitted comparably through IDU, and integration of HCV prevention and referrals (for testing and treatment services with providers who have agreed to participate) into the ENCORE program is therefore logical and efficient. In the pre-enrollment and follow-up interviews administered to ENCORE participants, they are asked whether they have been tested or would like to be tested for hepatitis C and whether they consider themselves to be at risk for hepatitis C. Responses to these basic questions will help ascertain the level of knowledge and understanding this high-risk population has regarding hepatitis C.

Vendors providing HIV counseling and testing receive thorough HIV education and certification. Hepatitis C information has been integrated into the education, which is conducted by a public health nurse. The goal is to encourage these vendors to educate their clients about hepatitis C by integrating HCV into HIV prevention materials, trainings, and staff development. The vendors subsequently make referrals to HCV testing services as appropriate. Public education materials and HCV screening and treatment guidelines have been distributed to providers

Behavior Risk Factor Surveillance System (BRFSS)

The BRFSS is an on-going data collection program, administered and supported by the CDC's National Center for Chronic Disease Prevention and Health Promotion. Surveys were developed and conducted to monitor state-level prevalence of the major behavioral risks among adults associated with premature morbidity and mortality. The information attained from the BRFSS is useful in describing the populations at risk for contracting HIV through their behaviors.

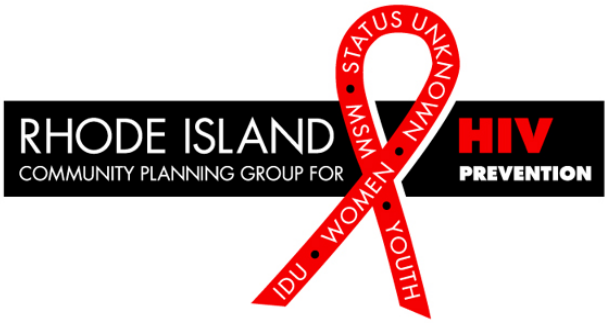
According to the 2000 BRFSS in Rhode Island, 31.5% of those surveyed indicated that they were at risk (either high, medium, or low) of getting infected with HIV (compared to 68.5% who responded there was no chance they could be infected with HIV). The BRFSS also revealed that 52.6% of those surveyed had been tested for HIV at some point in their lives, aside from routine screening when donating blood. 37% of those surveyed had been tested for HIV in the 12-month period prior to the survey, aside from routine screening when donating blood.

Youth Risk Behavior Survey (YRBS)

The Youth Risk Behavior Survey (YRBS) is an anonymous and voluntary survey conducted on alternate years among randomly selected high schools and students nationwide. The YRBS is developed by the Division of Adolescent and School Health at the Centers for Disease Control and Prevention (CDC). The CDC sponsored YRBS in 32 states and 18 localities nationwide in 2003. The YRBS monitors health risk behaviors that contribute to the major causes of mortality, disease, injury, and other health and social problems among both youth and adults in the United States.

In Rhode Island, in 2003 44% of high school students had sexual intercourse, a decrease from 46% in 2001. 8% of high school students were never taught about AIDS or HIV infection in school, a decrease from 10% in 2001. 47% did not use a condom in their previous sexual intercourse, an increase from 44% reported in 2001.

In Rhode Island, in 2003 45% of high school students had a drink of alcohol in the past thirty days compared to 50% in 2001. 44% reported ever using marijuana in 2003 a decrease from 48% in 2001.



Section 3
Community Service Assessment

The RICPG has assigned a Task Force to address the needs of four priority populations[1]:

- men engaging in unprotected sex with men and/or men engaging in unprotected sex with men and women.
- injecting drug users and other substance users and their partners
- women engaging in unprotected sex with men
- youth engaging in unprotected sex, alcohol and other drug use.

For more than two years, the Task Forces have gathered information about the priority populations in the form of a Community Service Assessment, comprised of three components:

- Needs Assessment
- Resource Inventory
- Gaps Analysis

A task force workbook is being drafted and piloted with selected task forces at this time. The workbook was designed to keep the task forces focused on how the community services assessment can help the task force and gather information to make recommendations to the RICPG. (Appendix E: DRAFT Task Force Workbook).

This Section of the Plan captures the work of the Task Forces.

Needs Assessment

Priority 1: Men engaging in unprotected sex with men and men engaging in unprotected sex with men and women.

[1] In the past, a fifth Task Force addressed the needs of people who don't know their status/HIV positives not in treatment. In 2003, however, the RICPG dissolved this Task Force and required the four remaining Task Forces to incorporate the needs of "unknowns" and people living with HIV & AIDS into their work.

The MSM Task Force continued to meet this year with several goals:

- Review last year's plan
- Identify additional and subsequent steps
- Recruit additional members
- Report back to RICPG
- Provide Report for the RICPG Comprehensive Plan

In reviewing last year's plan there are several issues that the Task Force is continuing to examine and follow up on.

Additional and Next Steps that the Task Force Identified:

Overall the Task Force recommends the use of both qualitative and quantitative information and data in conducting the community services and needs assessments for MSM. MSM of color and MSM who are living with HIV are priority populations that should be included in all of the recommendations of the MSM Task Force.

1. The Task Force identified "no identified risk" (NIR) as an issue and its possible relationship to MSM/gay men. For instance, what is the percentage of NIR in Rhode Island and how many of them are likely to be MSM or gay men?

   The Provision of Care Manager, who is a member of the Task Force, preliminarily reviewed the data for the AIDS Drug Assistance Program (ADAP) to determine if NIR corresponds to the epidemiological data. Initial draft findings showed that NIR for ADAP client database corresponded closely with the NIR in the epidemiological database. However, further and more detailed analysis is necessary for a better understanding of the NIR.

2. Identify additional vehicles, datasets and ways to gather information about status and risk.

3. Work with provision of care providers, counseling and testing sites and prevention providers to better ascertain sexual behavior of clients.

4. Determine if the sites are welcoming to MSM and LGBT clients/patients.

5. Identify training, professional development and other needs to increase awareness of, and access to HIV testing, prevention and care services for MSM and the LGBT community.

6. Review other social marketing campaigns that are effective in reaching MSM, especially MSM of color.

7. Update the RICPG on MSM behavioral risk, issues for MSM prevention, epidemiology, co-morbidities and surrogate markers for HIV risk.

8. Conduct a literature search on MSM and HIV prevention and identify trends, current issues and effective programs.

9. Incorporate cultural sensitivity training on gay, lesbian, bisexual and transgender issues into the REACH certification for HIV Prevention Specialists.

10. Identify additional MSM Task Force members to ensure broader community participation.

11. Gather additional information on MSM, gay men, especially MSM of color and people who are HIV positive. Possible vehicles for collecting information are:
    - Conduct focus groups with the following populations:
        - MSM of color
        - Young MSM
        - HIV positive MSM
        - MSM who frequent a local bathhouse
        - Population or location specific MSM (e.g. leather, "bears", older gay, etc.)

- Hold a community forum that would provide information on MSM and HIV and use the forum to get community feedback and "testimony" regarding their perspectives, experiences and knowledge.
- Contact other RICPGs and identify strategies and programs that have worked with MSM.
- Review and analyze data from the current case management survey (of both providers and consumers), the current survey from Counseling and Testing Sites, the LGBTI Community Scan conducted by the RHODE ISLAND Foundation, the current gay men's survey conducted by APRI and the survey from Youth Pride, Inc. (YPI).

12. Identify and convene key stakeholders to develop a plan of action.

Priority 2: Injecting Drug Users and other substance abuse users and their partners

In 2003, the Substance Using Disorder Task Force identified the following issues to explore through focus groups with providers and clients:

- What is the role of syringe exchange since the change in the relevant law? What is happening with the syringe exchange now that possession has been decriminalized?
- What is the current availability and access to IDU drug treatment issues?
- What are the substance treatment issues for inmates being released from prison? What are the contributions/barriers to access services for inmates discharged from prison?

<u>2003 IDU Task Force Recommendation Highlights</u>

Based on the focus groups discussions, the following highlights were identified:

- Access to services for the under and uninsured appears to be an ongoing problem. Clients talk about having to be intoxicated to get service. The funding for more uninsured beds is unlikely.

- There are a number of substance abuse treatment provider training issues identified. IDU have a complex array of issues such as lack of job training, social stigma, health problems, low-income housing and family strife that hinder and/or jeopardize their recovery process. The impact on the treatment programs includes a need for more professional development to meet these challenges, provider burnout prevention, and collaboration across agencies to coordinate care.
- ENCORE is not routinely used by IDU especially since syringes are available in the pharmacy. The program was rated highly by clients aware of the ENCORE van and the exchange sites. Programs that work for IDUs include elements of holistic care such as family involvement and reconciliation; spirituality; client centered timetables for treatment services; broad array of life skill training for clients; and linguistically and culturally appropriate staff and programs.
- IDUs in prison have an added stigma/complication of a criminal record. Service coordination for IDU being discharged from prison and jail appear to be non-existing.

During 2004, the task force continued to work on the issues in the following way:

- Clarify and refine the issues and create issue statements.
- Set priorities on the issues
- Determine a plan of action to address the issue in a manner appropriate to the RICPG mission.

<u>Clarify and refine the issues</u>

- IDU behavior category needs to be expanded to include crack users. The Safety Count (best Practice program) includes crack and IDU together because of cultural link.
- A number of "cross over" issues were raised such as communities of color, HIV positives and women and partners.
- Communities of color and PLWHA are now a part of all task force work. This was decided at the de-briefing meeting with the co-chairs and staff. It is more sensible to include the issues with each priority population/behavior.

Set priorities on the issues

The findings of the group were reviewed and the following priorities were set with a vote:

1. Access to services
2. Programs that work for IDUs
3. Discharge planning at the DOC for substance users
4. ENCORE awareness

Determine a plan of action

The primary issues centered on access to treatment and its role in HIV prevention. The task force agreed that clients in treatment and recovery were less likely to share syringes and engage in high-risk behavior (unprotected sex, multiple partners, untreated STI). The primary problem was identified as not enough treatment sites located in Rhode Island.

Discussion: Currently one site for detox of alcohol and opiate addiction is funded to provide care to uninsured clients. While residential care after detox may be the desired treatment option, there are issues: not all clients want to use it; there is a concern that it is the treatment of choice for the homeless; not enough beds and mental illness issues.

Access to care issues involving provider include: intake and screening procedures and documentation sharing between agencies are interfering with access to care.

There appears to be different "realities" about access to care based on the where one is coming from – a client or treatment staff/agency. What people say on the street about access to treatment is not necessarily the policy and practices at drug treatment agencies. In addition, there are issues that are associated with the disease process. There is a waiting list for indigent/uninsured clients, which is counter productive for this type of client. There is poor follow up by clients (3-5%) for entering treatment after being on the waiting list. Client's risk behaviors are inconsistent over time, personal issues and drug use changes.

There was a discussion about treatment modalities and methadone. Several articles about methadone were presented by a task force member. In addition, data from a local

methadone treatment agency on the number of clients testing positive for opiates and cocaine in the methadone program were as follows:

- Clients testing positive for opiates: 11.7%
- Clients testing positive for cocaine: 10.7%

While methadone is not the treatment of choice for some clients, there is research and professional literature that supports the use of methadone in the treatment of opiate addiction.

The group decided to gather data to inform their process. The epidemiologist from the Office of HIV & AIDS and the data manager presented ENCORE and IDU/HIV data. It was pointed out the there has been a drop in new HIV cases among IDU since the syringe exchange and law repeal. Also noted was the data showing communities of color are more affected by HIV, with Latinos reporting showing they are most affected by IDU infection transmission mode. The group requested race/ethnicity and gender data on people who learn they are HIV positive at the same time they learn they have AIDS. With the ENCORE program, syringe exchange, there has been a decrease in the number of people attending ENCORE, but not a major decrease in the number of syringes exchanged. Clients are exchanging for themselves and friend/partner. More clients are reporting difficulty getting into treatment.

A staff member from the Division of Behavioral Health presented data collected by that agency. The data is on individuals that are seen in licensed treatment facilities (does not include hospitals and non licensed facilities such as the Salvation Army, St Francis Chapel, Urban league and the Jewish Community Center.). Of the 18,679 admissions in 2003, 4,942 or 26% were IDUs. 98% of the IDU were heroin addicts. 25% of the IDUs had cocaine/crack as a secondary drug of choice. Of the 4942 IDUs treated, 2607 were white males and 1480 were white females (4087 total whites). 124 were black males and 67 were black females; 379 were Hispanic males and 123 were Hispanic females. The access to recovery for communities of color is much lower than for whites.

HIV status is considered confidential information and not collected in the substance abuse treatment data. Other issues not included are sexual trauma, domestic violence, viral hepatitis and sexual orientation.

The task force determined that the preparation of a "white paper" was the best course of action. Using a logic model, the task force is preparing to identify outcomes and strategies to include in the recommendations. An outline of the white paper is being prepared; it will include the history of the task force, the data and information gathered so far and recommendations to the RICPG.

Priority 3: Women Engaging in Unprotected Sex with Men

This year the Women's Task Force worked on their goals identified in the 2004 plan. The primary message that this group wants to include is that the Women's Task Force in their planning process has run up against as many obstacles in trying to gather data and assess needs as many of the clients do that cannot access the services. However, the group still remains optimistic and will continue to work toward turning obstacles into opportunities to better increase both quantity and quality of services for these women.

The group focused on the lack of appropriate questions on current forms when gathering information about HIV and the same discovery surfaced when the group began to look at STDs as a risk factor for HIV. Some of the flaws in current data collection included making the connection around violence. Examples from professionals serving women included the fact that even using the word violence may not connect with some of the women. If a woman has vaginal sex, being forced into anal sex may not occur to them as violence. They rarely ask a person if they are in an abusive relationship. They often don't ask about sexual orientation. Critical information is being missed due to poor instruments and insufficient field training in gathering information.

This group has identified a need for building the capacity of professionals in the field to interview and counsel in a way that will sensitively collect some of the data that is known but

not sufficiently documented. In addition, the group ran into union bargaining obstacles when considering who might best provide the training.

In their work on this task force the group revealed that many of the HIV interviewing forms were not specific and were more often a guidance tool. This flaw assumes that the professional interviewing will ask the needed questions. This group's experience with this population is that it often does not happen.

One of the highlights of the groups insights and discoveries were that the free clinics in both HIV testing and STD testing are not deemed responsive to the needs of the specific population that needs them. The hours for testing are Monday through Friday 9-4. People who might be using this service would most likely not be able to take a day off of work. If they were not working, one of the known characteristics of this population is that it takes courage to motivate themselves to go for testing and they need to be able to access it as soon as possible after they make the decision. Because of daily crisis and stressful demands, they may not be motivated or able to do it later. Therefore, it is the conclusion of this group that more services need to be offered with a more frequent and flexible schedule to include evenings and weekend hours. It is known that for a free HIV testing appointment one may be asked to wait 3-4 weeks. In families where crises and distractions permeate daily life, this wait is a missed opportunity for service providers. The group concludes that testing should be made available immediately upon request.

The group agreed that anything short of addressing these access issues is insufficient and does not respond to the needs of the population. This group will work continue to remedy this problem.

The group further explored the area of consumer friendliness and cultural competence in services for high-risk women. The group has key informant information and observations that lead them to know that some organizational climate issues exist that alienate consumers from getting the services they deserve.

The group has struggled with the issue of creating a consumer friendly climate instrument to substantiate the key informant information that concerns this group. In addition, the issue of how to implement the instrument has also been an obstacle to this group.
The RICPG is organized as a partner with HEALTH-RI; non HEALTH-RI vendors may not always welcome efforts in this behalf. Even HEALTH-RI-funded vendors may not greet this work with open arms. The group has discovered similar obstacles even working directly with HEALTH-RI. The group will continue to work toward enhancing collaboration in these efforts.

The group further discussed that free HIV testing should be offered by a variety of organizations. Competition to offer the best free service is good for Rhode Island. It increases the motivation to offer quality services; it increases the options for referring organizations while insuring quality care, and provides options for deserving women and other consumers of these services.

The group identified that Chlamydia is the number one sexually transmitted disease. If Chlamydia exists it is a sign that the woman is at risk for HIV. The need to focus on STD data to determine risk factors has resurfaced many times in the discussions of this group.

In addition to data collection needs, the group discussed the need for more evidence-based prevention strategies in Rhode Island.

The group is currently getting a more broad based perspective and soliciting feedback through inviting guest professionals to meetings for input.

Finally, the group has explored the option of creating a resource guide for women as a tool to help them access services available.

The work of this task force is not to negate or disregard the work and services of many qualified and caring professionals working in the service of women. The scope of this task force is to gather data, identify gaps, and recommend a strategy for improvement. This is the charge of the RICPG Women's Task Force.

Priority 4: Youth Engaging in Unprotected Sex and Alcohol and Other Drug Use

Due to the transition period in hiring a new facilitator, the youth task force has had the most difficulty in organizing to implement their goals. With the help of HEALTH-RI Administration, the goal of the youth task force to increase collaboration with parent outreach to involve more parents in talking to their youth about high-risk issues has been accomplished.

The group met on three occasions to prepare to implement their youth recruitment plan, and the meetings led to some internal issues that needed to be addressed before recruitment could begin. The group found that the RICPG general planning group needed to explore their readiness for serious youth participation.

In the beginning the group meeting structure was designed to meet for a full day in order to accomplish the other work of committees and task forces, unfortunately this structure proved not to be the best for youth participation. The group was interested in reaching high school students who could not take time out of school to attend day-long RICPG meetings. Therefore, this format would not serve to interest or retain youth in a meaningful way.

The growth opportunities have been steady in the attempts at organizing for the implementation of youth involvement strategies. Although the obstacles have been many, the results of their struggle influenced a change in schedule for the overall RICPG. The RICPG planning group now consists of two half-day meetings per month, including one held during the evening. This will increase the likelihood that we can include youth representation in the general planning meetings.

The group identified capacity building training issues as a result of their experience, and in collaboration with the REACH Capacity Building Committee, training on youth involvement strategies are now scheduled in the REACH training catalog.

In addition, the group formed a think tank experience on possible strategies to involve youth. Included in the discussion are:

- Looking to a local college and provide cash and college credit incentives for a Coordinator to facilitate a youth advisory group.
- Recruit older youth out of school, who may be in recovery from substance abuse, who would still be in tune with the needs of high risk youth.
- Making a youth coordinator position as part of HEALTH-RI's RFP process.
- Calling other RICPGs to see how they have addressed the issue.
- Contact some already established groups of teens through the substance abuse prevention taskforces throughout Rhode Island.

The youth task force has not met recently, but the benefits of their work are being implemented to assure that the RICPG planning group is ready, youth friendly, and capable of involving youth contributions in a serious manner.

The group has been successful in identifying internal needs: the outcome resulted in some RICPG reorganization; the facilitator is taking the input and calling other RICPGs and organizations, and the capacity building training is scheduled.

Youth needs will be discussed in large group until the task force recommendations are in place. At that point the youth task force will begin implementing the plans for needs assessment involving youth input.

The group discussed supervision issues, the need to have clear expectations of the youth involved, and the youth friendly changes that needed to take place in the RICPG structure.

Prevention for Positives Needs Assessment

Using supplement funding for HIV prevention, HEALTH-RI initiated an assessment to determine the prevention education service needs of people living with HIV/AIDS. The assessment took many forms and had to pass through HEALTH-RI's Human Subject

Committee review. In 2004, HEALTH-RI began conducting surveys of HIV case managers and their clients to determine the capacity building assistance needs of HIV case management providers to deliver prevention education services to person living with HIV. The case management surveys were followed up with focus groups with the case managers. A report on the case manager surveys and focus group results has been completed.

Client surveys (available in English and Spanish) are being conducted by HEALTH-RI staff through face-to-face interviews and telephone interviews. As of August 2004, 75 clients had been interviewed with an expected total of 150 client surveys.

Rationale

The yearly needs assessment conducted by the Ryan White program surveys clients and providers on the need and availability of services such as transportation, housing, mental health services and access to medical care. The amount of HIV prevention case management, risk reduction and/or risk management offered to HIV positive clients is not known. Since an accurate picture of prevention services is not available, HEALTH-RI conducted an assessment of the capacity of case manager to offer prevention services to HIV positive clients in their care. Included in their survey process will be questions for clients on their perceived need for prevention services. Using the "perceived need" model of inquiry will be the first step in using the Stages of Change model of behavior change, which has been shown to be successful with condom use and the adoption of other harm reduction behaviors. An assessment is a critical first step in the creation and implementation of an effective capacity building plan for HIV prevention services for HIV positive clients.

Additional Comments on Needs of Underserved Populations

The Office of Minority Health has provided continuation grants to do HIV/AIDS education/risk reduction to under-served populations identified by the RICPG; they are Asian Americans, Women of Color in Prison and Newly Released, and Native Americans.

Asian Americans

A questionnaire has been developed to gather further information from the Southeast Asian community. A community forum is scheduled for this contract year. Continued effort to identify individuals who are key players in the Asian community is an ongoing process, and to date, two community's stakeholders have been identified, as well as the Providence Centers Southeast Asian Services. We continue to acquire more insight into the needs, concerns, and barriers within this community through constant dialogue with community members and individuals involved with the Southeast Asian community.

Women of Color In Prison and Newly Released

The third round of peer education training with program participants from prison and training school is being done. To date, WomenCARES has provided sessions via their peer educators to inmates, on advanced skills building in the areas of HIV/AIDS transmission, domestic violence, STDs, self-esteem, healthy relationships, negotiating, cultural competency, decision making and presentation skills.

WomenCARES has developed a relationship with the discharge planners at the women's prison, and Sojourner House has been added as a resource on the discharge planners' lists for newly released women. WomenCARES is also notified when women are being released who have no source of transportation from the prison, and they will provide them with transportation as well as case management through their agency. WomenCARES has also been added to the discharge referral list that is given to inmates when they are discharged.

WomenCARES peer educators are providing four 8-week GLI groups for the women in prison. There are no ongoing groups within the training school at this time due to the fact that there are not enough girls in the training school who have elevated to that level.

Native Americans

The Narragansett Indian Tribe in collaboration with the Rhode Island Indian Council continues to provide rural and urban Native youth with HIV information in a culturally appropriate manner. The 2003-2004 contract year ended with a four-day retreat at Whispering Pines, entitled *Awakenings*, for Native youth, utilizing the Elders of the tribe, Native musicians and peers to look at the health issues that are affecting Native American

youth. The sessions were very informative and they brought in the importance of spirituality from a cultural point of view. The youth were active in these workshops and were able to express themselves on a variety of levels and the issues that affect them on a daily basis.

They began their new contract year with a one-day workshop on program development, which was attended by the Narragansett Indian Youth Council, Rhode Island Indian Council Youth, as well as spiritual leaders and tribal council members.

Weekly group level intervention sessions are held with native youth, addressing such issues as HIV/AIDS, domestic violence, STIs, traditional morals and values, cultural preservation among Native youth, and healthy lifestyles. The youth have also attended two Health Living Day retreats, one of which took place at Purgatory Chasm in Massachusetts. Twenty-two youth and youth leaders hiked into and around the chasm, partaking in a spiritual re-awakening ceremony, which assisted in the propelling and strengthening of the concepts and rewards of practicing healthy lifestyles. Additional workshops addressing problems such as infectious diseases focusing on HIV virus, substance abuse and domestic violence within the native community are also ongoing.

The Narragansett Indian Tribe ended their 2003 contract year with a four day retreat for Native youth which was held at Whispering Pines on the campus of Alton Jones. Their theme focus for this year was "Awakenings" which focused on health and cultural inclusion of addressing the health needs of the Native people. The retreat was attended by youth from the Narragansett Indian Tribe and the Rhode Island Indian Council. Presently, they are conducting workshops for the new calendar year and their first series is entitled "How We Live"—a collaborative gathering with HIV Awareness Program of the American Indian Community House in New York City.

Needs Assessment				
Objective	**Activities**	**Output**	**Immediate Outcome (2005)**	**Intermediate Outcome (2009)**
To continue to conduct a needs assessment based on the priority population/ behaviors using coordinated community assessment strategies	• Continue to facilitate a plan to conduct a community assessment • Facilitate the priority population/ behavior task forces meetings • Conduct activities associated with each task force plan • Train staff and RICPG in community assessment strategies	Task Force Report(s)	The RICPG has additional information to assist in the priority setting process.	RICPG members are prepared to act on the tasks associated with community planning.

Resource Inventory

The RICPG Strategic Planning Committee has assumed the responsibility for the development of a new process for collecting data for a resource inventory that can service both providers and consumers. Prior efforts at the resource inventory were inefficient in managing and updating the data. The old inventory was based on the responses to a survey sent to agencies throughout Rhode Island. Because of the time consuming nature of this process and the low return of surveys, a process to update the inventory in a more cost

effective manner had to take place. In addition, the survey needs to include all the services for HIV prevention and treatment (Ryan White, all Titles), and HCV testing and HCV treatment resources.

In 2004, HEALTH-RI undertook the process of developing of a new approach to the resource directory by assessing other directories in the state. Exploring the possibility of sharing data with other agencies that have resource directories appeared to be the most efficiency approach. In Rhode Island, a social services agency is funded to manage and update a state wide Human Service Directory. This Directory is well known to the community. After discussions with the agency staff involved with the directory's development and updates, it became apparent to HEALTH-RI that copyright issues and computer system incompatibility were going to make sharing data difficult. At that time, HEALTH-RI made the decision to develop an HIV/HCV specific database and resource inventory. It was determined that if the directory focused on HIV and HCV (and did not attempt to duplicate the current human services directory), the undertaking was possible with current staff and computer capacities.

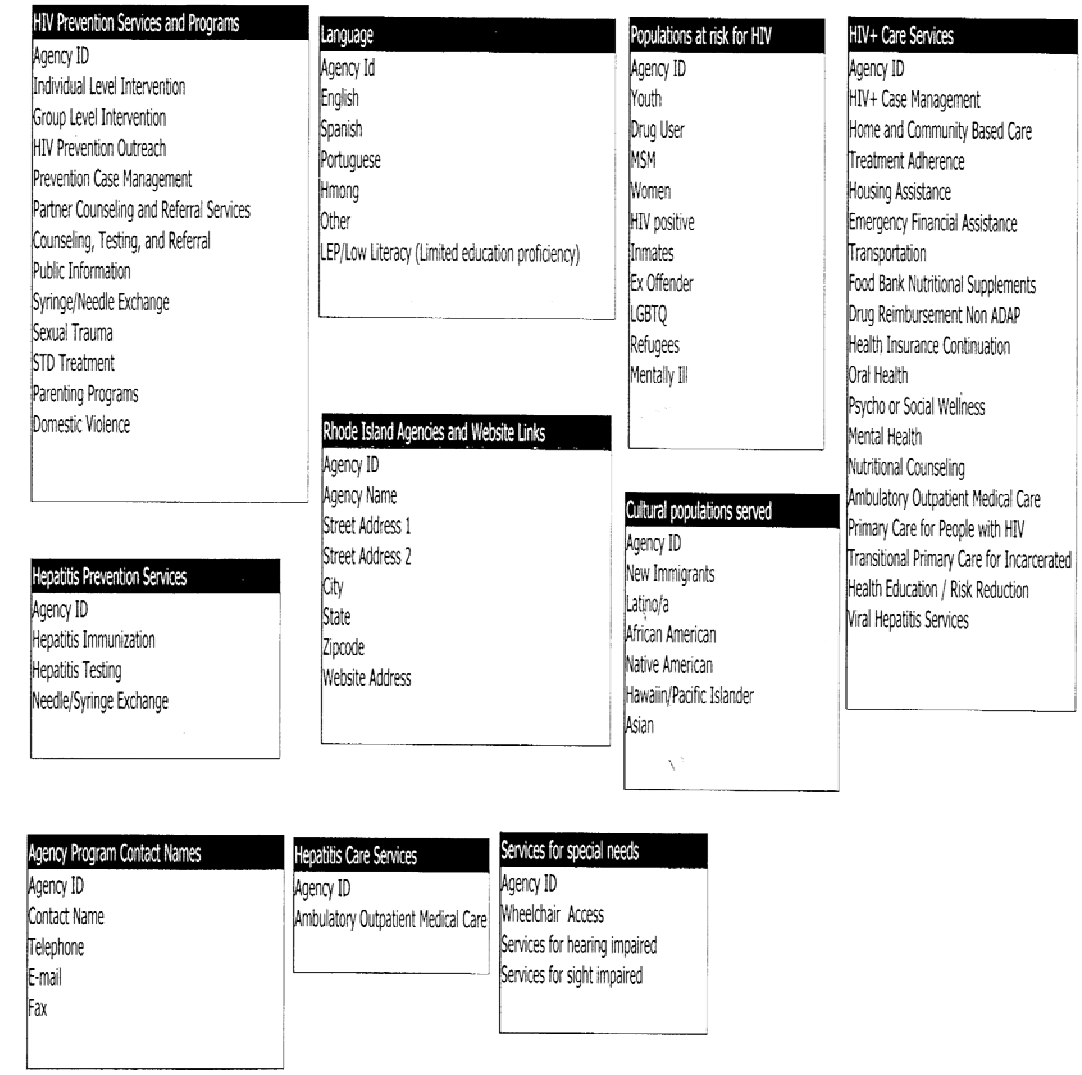
The new database would need to meet the following criteria:

- The database would have to be flexible enough to allow for the needs of both a client and a provider audience.
- The database would have to be formatted so that it could be easily updated and corrected by staff.
- The database would have to have the capacity for the development of both a hard copy and web site format.
- The page lay out and design would need to be simple enough to meet the need and capacity of the audience.
- The resource inventory would need to include HIV/AIDS prevention and treatment information; HCV treatment and prevention and have information on how to access other related agencies such as substance abuse and domestic violence.

The HEALTH-RI data manager identified the following relational content areas for the content for the database to be presented to the Strategic Planning Committee. (See Next Page.)

Relationships for Copy of HIV Services Resource Guide

Wednesday, August 04, 2004



By December of 2004, the HIV Resource Guide will be ready for publication. Clients and providers will be able to access information about services from any of the categories described in the previous page. For example, if a provider was helping a Spanish client to access services, the provider could look up language Spanish and find a list of prevention and care services. If a gay client was looking for LGBTQ friendly services, they could click on LGBTQ and have listing of services and their description. Categorizing the services improves client access and will also assist the RICPG in identifying services that are needed.

Case Manager Perspectives of HIV Prevention Education Needs for their HIV Positive Clients.

Introduction

HEALTH-RI was interested in better understanding the prevention education needs of people living with HIV. In order to do so, surveys were conducted with 19 Case Managers who serve HIV positive clients at the four sites funded by HEALTH-RI (AIDS Care Ocean State, AIDS Project Rhode Island, The AGAPE Center, and Family Services) from December 2003 to January 2004. Oral comments were also recorded during a post-survey discussion about the issues the Case Managers thought were important regarding helping their HIV clientele avoid further transmission of HIV.

Survey Results

Demographics

The average age of the HIV case managers is 43 with about 53% white, 12% black, and 35% other races. About 27% of the HIV case managers are Hispanic or Latino. The majority (47%) of the HIV case managers have a bachelor's degree, while 16% hold an advanced degree and 21% an associate's degree.

Assessing Knowledge

Most HIV case managers (72%) rated their client's level of knowledge about HIV risk reduction behaviors as okay (that if applied would prevent them from spreading HIV/AIDS to others using a scale where 1=severely deficient, 2=okay, and 3=excellent), with the other 28% as excellent. The ratings for their client's motivation in following through with risk reduction behaviors were very similar with 78% rating them as okay, 6% as severely deficient, and 17% as excellent. The ratings for their client's skills in following through with risk reduction behaviors were slightly less, however, with 67% as okay, 22% as severely deficient, and 11% as excellent.

The case managers appear to be able to communicate the client's level of risk of spreading HIV a good portion of the time with 5% saying they are never able to communicate the level of risk, 47% sometimes, and 47% always able to communicate the level of risk. Likewise, case managers are usually able to assess the client's readiness to change behaviors that risk spreading HIV to others with 11% stating that they are never able to assess readiness to change behaviors, 58% sometimes able to assess readiness to change behaviors, and 32% always able to assess readiness to change behaviors.

Ability to Apply Risk Reduction Strategies

Slightly fewer case managers are able to set risk reduction tasks that can be easily accomplished with their clients with 16% never able to set tasks, 58% sometimes setting tasks, and 26% always setting tasks. Given that change efforts are implemented, a higher percentage of case managers are able to follow-up with their clients to re-enforce change efforts, discuss problems encountered, and further encourage risk reduction changes with 11% never following up, 47% sometimes following up, and 42% always following up. In order to get an idea of what the case managers were experiencing with their clients we also asked how effective the case manager thinks setting risk-reduction tasks that clients can accomplish is in reducing behaviors that are considered risky in spreading HIV. About 11% didn't think setting risk-reduction tasks were effective at all, 61% somewhat effective, and 28% very effective. Most case managers (84%) always feel comfortable discussing risk

reducing strategies with their clients, with the rest (16%) only sometimes feeling comfortable discussing such strategies.

Training

Most of the case managers (90%) feel they have been given the training and information necessary to provide the clients with the information and support they need to reduce the spread of HIV and manage their infection. A slightly smaller amount of case managers (74%) feel they have been given the training and information to understand the cultural/ethnic background and/or lifestyle of his/her clients or acquired enough experience. Given the amount of case managers who feel they have cultural competency regarding their client's cultural background, 90% of the case managers feel it is important to understand the cultural/ethnic background and/or lifestyle of their clients.

Risk Reduction

A large percentage (84%) of case managers feel comfortable discussing risk reducing strategies with their clients. When asked how often the case manager is able to talk with his/her clients about safely using needles/syringes, how to properly use a condom, and about having unprotected sex with individuals who are either infected or uninfected individuals while on medication. The results are shown in Tables 1-4.

Table 1. How often Case Managers talk with his/her clients about safely using needles/syringes (for medical or recreational drug use).

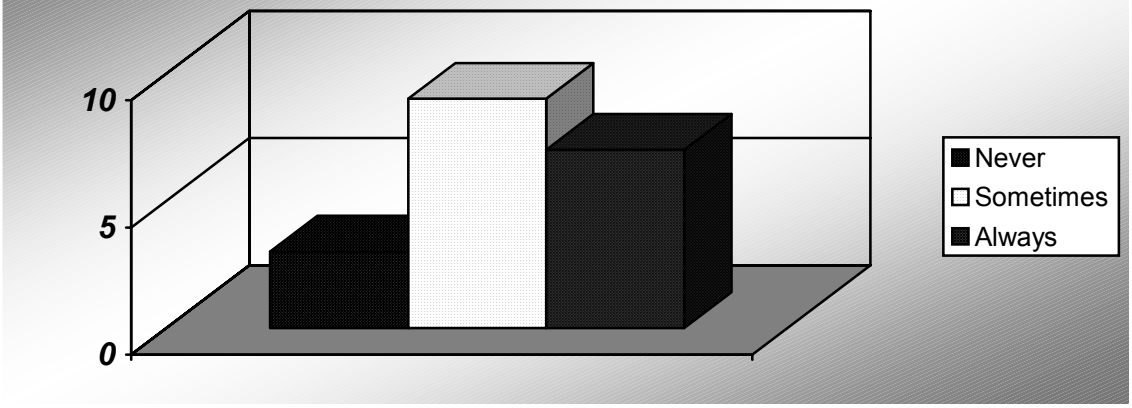


Table 2. How often Case Managers talk with his/her clients about safely using needles/syringes (for medical or recreational drug use).

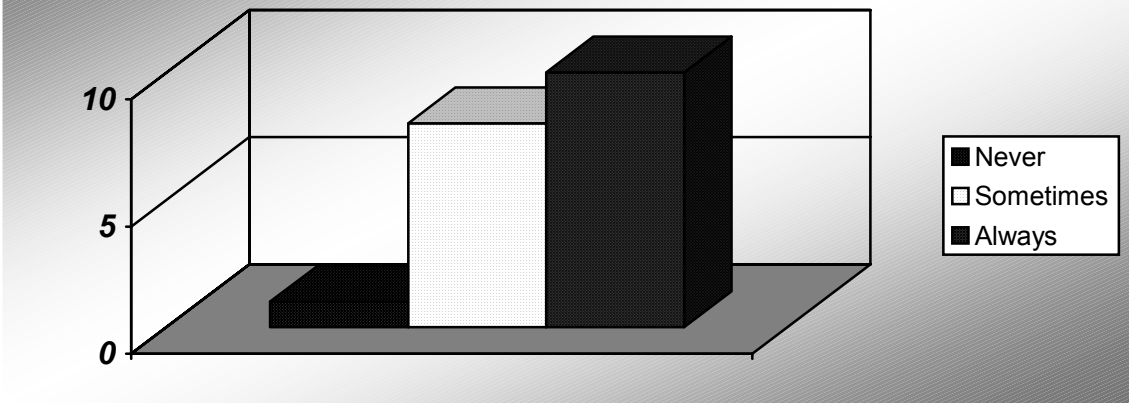


Table 3. How often Case Managers talk with his/her clients who are on medication for HIV/AIDS about unprotected sex with individuals who are uninfected with HIV.

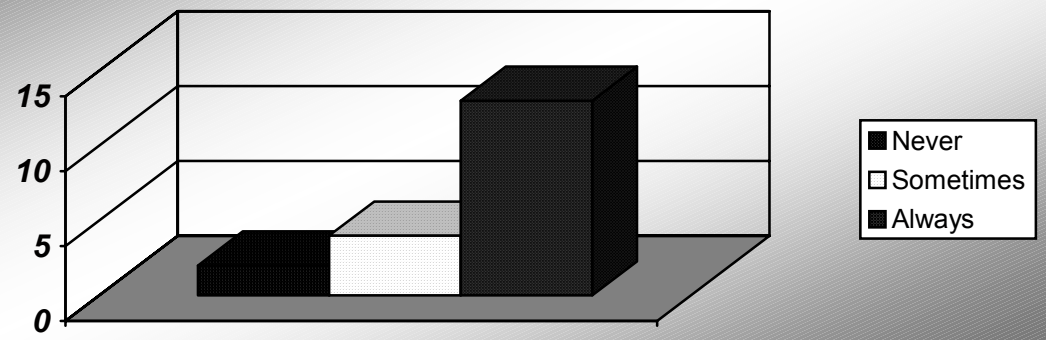
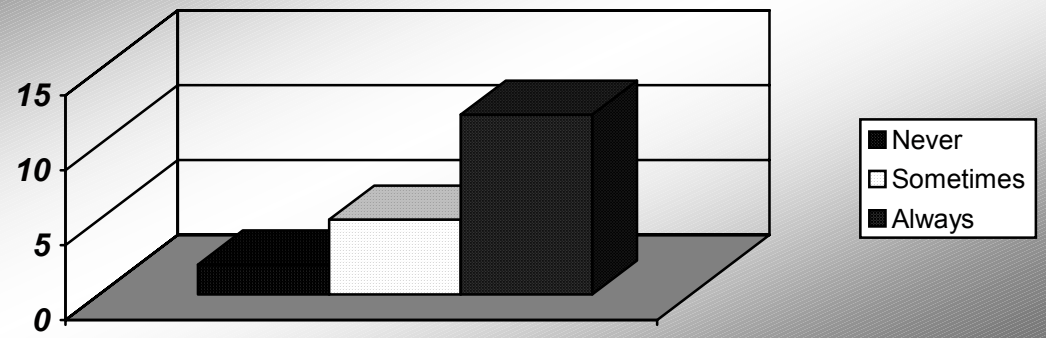


Table 4. How often Case Managers talk with his/her clients who are on medication for HIV/AIDS about unprotected sex with individuals who are *infected* with HIV.



When asked what the most important thing is that would help the case managers help the HIV+/AIDS clients adhere to risk reduction behaviors, 58% suggested alleviating social factors that keep the client from adherence. The remaining case managers (21%) chose training to learn more skills to help change risky behaviors, (5%) more time with each client, (5%) improving the clients abilities to keep appointments, and (5%) addressing substance abuse in high risk behavior as the most important thing to help case managers help the HIV+/AIDS clients adhere to risk reduction behaviors.

Case Manager Comments

Three of the four sites felt that HIV prevention education was an integral part of the case managers duties, while the fourth felt that their time was filled with taking care of their client's basic survival needs and that they had little time and energy left to talk about preventing transmitting HIV/AIDS to others. Some individuals at this site preferred to direct clients to medical professionals to make sure they were getting necessary HIV prevention knowledge, modeling to the client that they should ask a professional medical person any questions they may have concerning their condition or prevention against spreading the disease. Overall, most case managers stated that they discussed basic prevention issues with their clients when the opportunities arose.

Case managers targeted several topics they thought were important to address among their HIV positive clients to help reduce the spread of HIV.

Disclosure barriers

Many clients have difficulty in talking about their HIV status to potential partners or family members. There are not criminal laws in Rhode Island regarding an HIV positive person having sex with another without telling them about their status. There are also additional cultural barriers such as the disinclination of Hispanics to wearing condoms because doing so is a sign of infidelity among partners.

Lambskin condoms

Many clients ask whether Lambskin condoms are effective in preventing the spread of HIV to their partners. Some individuals are sensitive to latex or prefer the feel of lambskin over latex. Alternatives to latex condoms would be helpful for this population.

Re-infection -- Unprotected sex with other HIV positive individuals

In general, case managers stated that it is difficult for their clients to understand why it is important for them to continue to practice preventive measures with HIV positive partners. The attitudes of the clients, due to the terminal condition of their status and the difficulty in understanding how mixing strains of HIV might affect them or their partners, leads to difficulty in solidifying preventive behavior and/or practices with HIV positive partners.

Drug Use

One of the main issues that the case managers struggle with in the HIV positive population is drug use. Drugs may or may not have been involved in contracting the infection, but are often a means of escaping the realities of having HIV. The use of mind-altering drugs directly affects the ability for the clients to practice risk reduction behaviors.

Cultural Competency

There was an overall agreement of the importance for culturally specific pamphlets/brochures and videos written in different languages such as English, Spanish, Portuguese, Cambodian, and Laotian. Differences in cultural values directly affect the specific needs in preventing the spread of HIV, which the case managers see and do try to address as their knowledge about the culture increases.

Resource Needs

Case managers would welcome more free condoms or wider availability of free condoms, since convenient access to condoms is often difficult for the HIV positive population. Female condoms are particularly difficult to find in the retail stores. More pamphlets/brochures and videos were also called for to better reinforce education messages about how to use a condom correctly, the importance of not spreading different strains of

HIV/STDs, and topics regarding the use of sex toys. Again, educational material needs to be translated into several different languages.

Other comments included disseminating more information about post prophylaxis procedures, the partner notification program, more HIV classes for new case managers, the possibility of using a specific case manager to talk to clients about preventing the spread of HIV and the possibility of having a therapist/clinician on site who could help the clients with their healing process which would, in turn help nurture attitudes and motivate the clients to help prevent the spread of HIV to others.

Discussion

Most 3 level scale survey questions yield middle answer results, and these results are no exception. The results offer insight into what is happening among the client population according to the case manager's perspectives, and can be used to help set future objectives.

For instance, the survey results show that almost half of the case managers are sometimes able to communicate the client's level of risk of spreading HIV with the same amount always able to communicate the client's level of risk. Because of the many contextual factors involved with the case managers and clients, more investigation would be helpful to further elucidate why some case managers feel they are always able to communicate risk, others only sometimes and others not able to at all. Objectives could be set to try to raise abilities of case managers to communicate the client's level of risk or to assess readiness to change behaviors among the clients.

Likewise, objectives may also be set to decrease the 22% of the case managers who rated their clients as severely deficient in reducing risk reduction behaviors and raising the 11% of case managers who rated most of their clients as excellent in reducing risk reduction behaviors through various interventions targeting either or both client and case manager needs.

Resource Inventory				
Objective	**Activities**	**Output**	**Immediate Outcome (2005)**	**Intermediate Outcome (2009)**
To continue to conduct a resource inventory of services associated with HIV/AIDS prevention and treatment.	Explore cost effective methods of gathering inventory information. Conduct resource inventory update for 2005. Make inventory available on HEALTH-RI web site.	Updated resource inventory to include Ryan White services and substance abuse treatment centers offering HCV testing.	The RICPG has additional information to assist in the priority setting process.	RICPG members are prepared to act on the tasks associated with community planning.

Gap Analysis

2002 was the year that the RICPG Strategic Planning Committee initiated the gaps analysis process. In 2003 the process was revised to include:

1. Review of the priority population/behavior determined by the RICPG.
2. Review the current set of HEALTH-RI funded HIV prevention programs, Ryan White funded programs and community partners.
3. Identity gaps by type of intervention and location of services for each priority population/behavior identified by the RICPG.

Please note that the key to all strategies and services is as follows:

- **ILI**—individual level intervention
- **GLI**—group level intervention
- **PCM**—HIV Prevention Case Management
- **TO**—Targeted outreach
- **CTR**—HIV counseling, testing and referral and partner notification services
- **PI**—public information/education

The RICPG priority populations served are identified by a colored check mark. The color code is as follows:

Priority 1 - Men Engaging in Unprotected Sex with Men and men and women

Priority 2 – Injecting Drug Users and other substance users and their partners

Priority 3 – Women Engaging in Unprotected Sex with Men

Priority 4 - Youth Engaging in Unprotected Sex and Alcohol and Other Drug Use

Priority 5 – People Who Don't Know Their Status/HIV Positives Not in Treatment

Agency	Services						Comments
	ILI	GLI	TO	PCM	CTR	PI	
Adams Clinic					MSM Y DK		HEALTH-RI CTR funded site that focuses on the CTR needs of youth and MSM youth.
AIDS Care Ocean State	MSM IDU W Y		MSM IDU W Y K	MSM IDU W Y	MSM IDU W Y DK	MSM IDU W Y DK	Ryan White and state funded HIV case management and other services for HIV positive clients.
AIDS Project RI						MSM IDU W Y DK	HEALTH-RI HIV Prevention funded Ryan White and state funded HIV case management and other services for HIV positives
AIDS Quilt Rhode Island						Y DK	HEALTH-RI HIV Prevention funded Provides quilt making and other public information events with the AIDS quilt.
The Agape Center, Inc				IDU W			HIV case management/Ryan White funded
BRUNAP							Brown University Provider Education Program
Can We Talk Rhode Island?							Addresses parent education needs with youth on HIV/AIDS. Groups through out the state in varied venues.
Caritas, Inc.	IDU Y	IDU Y					HEALTH-RI HIV Prevention Substance Abuse Treatment/ offer HIV and STD testing
Chad Brown Health Services					MSM IDU W Y DK		HEALTH-RI funded CTR

Agency	Services						Comments
	ILI	GLI	TO	PCM	CTR	PI	
CHISPA		W					HEALTH-RI HIV Prevention Multi-purpose social service agency serving the minority community.
CoastalMedical					MSM		HIV positive medical treatment
CODAC I, II, III	IDU	IDU					Substance Abuse Treatment/HCV screening/offer HIV and STD testing
Community Access/ Bridge Project	MSM IDU W Y DK				MSM IDU W Y DK		HEALTH-RI Ryan White funded for Discharge Planning of HIV Positives inmates HEALTH-RI funded CTR
Department of Child, Youth and Families					Y		Offer HIV and STD testing to incarcerated youth
Department of Corrections	MSM IDU W DK	MSM IDU W DK			MSM IDU W DK		HEALTH-RI HIV Prevention funded Mandated HIV testing of sentenced adults
Department of Education							HEALTH-RI funded teacher education on HIV/AIDS. Community partner
HEALTH-RI – Family Health					MSM IDU W Y DK	MSM IDU W Y DK	Title X CTR grant Parent education partner and co-funder of parentlinkri.org
Family Health Services – Cranston and Coventry					MSM IDU W Y DK		HEALTH-RI funded CTR

Agency	Services						Comments
	ILI	GLI	TO	PCM	CTR	PI	
Family Service of Rhode Island	MSM IDU W Y DK						HIV case management/Ryan White and state funded
Hospice	MSM IDU W						HEALTH-RI Ryan White funded/HIV positives home health care
House of Compassion	MSM IDU W					MSM IDU W	HEALTH-RI Ryan White funded/HIV positives home health care
Map – Minority Alcohol and Drug Rehabilitation, Inc.		IDU	IDU		IDU		HEALTH-RI HIV Prevention funded Substance Abuse Treatment offer HIV and STD testing
Caritas House and Martin Luther King Center		Y					HEALTH-RI HIV Prevention
Matthew 25 HIV/AIDS Ministry	MSM IDU	MSM IDU					HEALTH-RI Ryan White funded Primary prevention for HIV Positives
Memorial Hospital of Rhode Island					MSM IDU W Y DK		HEALTH-RI funded CTR
Miriam Hospital	MSM IDU W DK			MSM IDU W DK	MSM IDU W Y DK		HEALTH-RI Ryan White funded/Discharge Planning and Post Release Case Management for HIV positive inmates HIV positive medical treatment
Narragansett Indian Tribe		Y					Office of Minority HEALTH-RI project with the Office of HIV & AIDS staff

Agency	Services						Comments
	ILI	GLI	TO	PCM	CTR	PI	
New Visions of Newport					MSM IDU W Y DK		HEALTH-RI funded CTR HIV positive medical treatment
Neighborhood Community Health Centers					MSM IDU W Y DK		Community Health center with extension grant to provide indigent health care
Northern Rhode Island Community Mental Health Services	MSM IDU						Ryan White funded Mental Health counseling for HIV positives
Planned Parenthood of Rhode Island		W Y	W Y		W Y	W Y	Community partner serving women and youth
Progreso Latino		W	W				HIV Prevention funded Multipurpose Social Service agency serving the minority community
Rhode Island College							HEALTH-RI funded teacher education on HIV/AIDS
Rhode Island Hospital				MSM IDU W			HIV positive medical treatment especially substance users with HCV and mental health issues
Rhode Island Parent Information Network							Parent groups including Can We Talk? and community partner
Roger Williams Medical Center		IDU W		MSM IDU W			HIV positive medical treatment HCV Support Group

Sojourner House	MSM IDU W Y DK	MSM IDU W Y DK	MSM IDU W Y DK				Domestic Violence Program HEALTH-RI HIV Prevention funded Work with incarcerated youth

Agency	Services						Comments
	ILI	GLI	TO	PCM	CTR	PI	
STD Clinic					MSM IDU W Y DK		HEALTH-RI funded STD diagnosis and treatment
Traveler's Aid of Rhode Island			MSM IDU W Y DK		MSM IDU W Y DK		HEALTH-RI funded CTR HEALTH-RI funded hepatitis immunization project for runaway youth Multiple service agency for homeless
Tri-Town Health Center					MSM IDU W Y DK		HEALTH-RI funded CTR Community Health Center Title X services
Urban League of Rhode Island	IDU	IDU					HEALTH-RI HIV Prevention funded Multiple social service agency
Visiting Nurse Services					MSM IDU W Y DK		HEALTH-RI funded CTR
Youth In Action, Inc	Y	Y	Y				HEALTH-RI HIV Prevention
Youth Pride, Inc	Y	Y	Y				Gay, lesbian, transgender, questioning youth support agency

Identified Gaps by Priority Populations/Behaviors

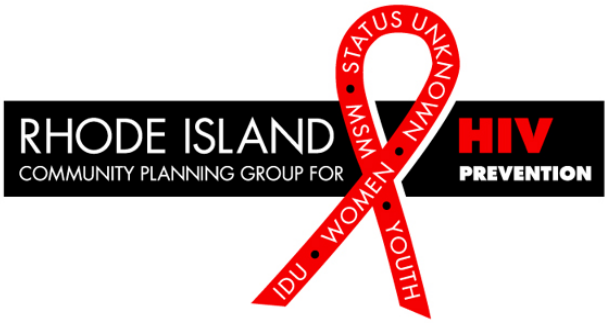
Gaps Priority 1 MSM:
Intervention: PCM, CTR, ILI, TO, GLI
Geography: State wide

Gaps Priority 2 IDU:
Intervention: PCM, GLI, TO
Geography: Woonsocket, Newport, non-urban areas

Gaps Priority 3 Women:
Intervention: ILI, GLI, PCM, TO
Geography: Woonsocket, Newport, non-urban areas

Gaps Priority 4 Youth:
Intervention: ILI**,** GLI, CTR, PCM
Geography: Woonsocket, non-urban areas

Gaps Priority 5 Don't Know Status:
Intervention: CTR, TO
Geography: Woonsocket, non-urban areas



Section 4
Setting Priorities

Introduction

The process of presenting a priority setting protocol to the RICPG has been a continuing challenge because of differing adult learning styles, expertise, biases, and the natural passion of a group of individual community advocates.

In 2003, a training and accompanying workbook (Appendix F: Welcome to Setting Priorities with the Rhode Island Community Planning Group for HIV Prevention) was offered to the RICPG.

HEALTH-RI was to take feedback on this process and improve the training and the workbook for future priority-setting activities. This was an attempt to anticipate the group's needs for the development of the next five-year comprehensive planning process from 2005-2009. The RICPG essentially needs to conduct priority-setting updates every three years to coincide with the request for the proposal schedule that HEALTH-RI issues for HIV prevention services. On a three year cycle, the funding for services needs to reflect the RICPG priority setting as demonstrated in the most recent RFP. The cycle of priority setting and HIV prevention services funding is as follows:

Year	Major Activities Performed by the RICPG	Major Activities Performed by HEALTH
2005	RICPG assessment activities are directed and focused through the use of the task force workbook. (Appendix E: DRAFT Task Force Work Book) Committee activities are directed and focused through the committee workbooks. (Appendix G: Committee Workbooks)	• RICPG facilitation • Social Marketing of the RICPG, Plan and the annual conference. • Capacity building of the RICPG by updating and revising workbooks; providing leadership and team building trainings. • Capacity building and

		credentialing of the provider community through Project REACH. • The services of the epidemiologist are made available to the task forces.
2006	RICPG Assessment Activities – task force outcomes are presented to the Strategic Planning Committee Activities. RICPG – Strategic Planning Committee activities are used to develop the comprehensive Community Service Assessment. RICPG task force activities include assessment of the capacity building issues among community providers. RICPG task force capacity building assessments are used to update the REACH needs assessment process.	• RICPG facilitation • Social Marketing of the RICPG activities and annual conference • Capacity building of the RICPG by providing leadership and team building trainings. • Capacity building and credentialing of the provider community through Project REACH. • The services of the epidemiologist is made available to the task forces and Strategic Planning committee
2007	RICPG – Review the work of the Strategic Planning Committee on the community service assessment to adjust and reset priority populations and interventions. The RICPG use the priority setting workbooks to update	• RICPG facilitation • Social Marketing of the RICPG activities and annual conference • Capacity building of the RICPG by providing

	priority populations/behaviors and interventions. RICPG use outcomes from the task forces and committees to advise and make recommendations to HEALTH on the request for proposal for HIV prevention services, policy changes and capacity building issues needs.	leadership and team building trainings. • Capacity building and credentialing of the provider community through Project REACH. • The services of the epidemiologist is made available to the task forces and Strategic Planning committee • The priorities set by the RICPG are incorporated into the new RFP for HIV prevention services issued in the fall, 2007. The services will be a three cycle starting January 1, 2008-December 31, 2010. • Task Force Workbooks and committee workbooks are updated and revised for 2008 activities.
2008	RICPG assessment activities are directed and focused through the use of the task force workbook. Committee activities are directed and focused through the committee workbooks.	• RICPG facilitation • Social Marketing of the RICPG, Plan and annual conference • Capacity building of the RICPG by updating and revising workbooks;

		providing leadership and team building trainings. • Capacity building and credentialing of the provider community through Project REACH. • The services of the epidemiologist are made available to the task forces.
2009	RICPG Assessment Activities – task force outcomes are presented to the Strategic Planning Committee Activities. RICPG – Strategic Planning Committee activities are used to update the Community Service Assessment. RICPG task force activities include assessment of the capacity building issues among community providers. RICPG task force capacity building assessments are used to update the REACH needs assessment process.	• RICPG facilitation • Social Marketing of the RICPG activities and annual conference • Capacity building of the RICPG by providing leadership and team building trainings. • Capacity building and credentialing of the provider community through Project REACH. • The services of the epidemiologist is made available to the task forces and Strategic Planning committee

Goal Two: The Rhode Island Community Planning Group identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in Rhode Island.

Indicator E.2: Proportion of key attributes of an HIV prevention community process that RICPG membership agreed have occurred.

Population/Behavior Priorities

Using the Welcome to Priority Setting with the Rhode Island Community Planning Group for HIV Prevention workbook, the members were taken through a step-by-step discussion. According to the objectives, the members would:

1. Consider the importance of setting priorities to target resources toward people most in need of HIV Prevention services.
2. Consider factors to set fair and knowledgeable priorities using risk behaviors and social conditions.
3. Use the factors to set priorities using an individual scoring sheet.
4. Determine a group consensus on priorities.
5. Determine the best interventions for each priority population/behavior.

The priority setting was a three-step process:

1. Members reviewed the workbook during the regular meeting. This included a lengthy discussion about the data sets available to them, the definition of risk behaviors, the barriers that hinder people's access to services, and the rating of behaviors and risk for infection.
2. Members were encouraged to review the workbook at home at their own speed and note their questions, concerns, etc.
3. Members signed up for one of three small group workshops scheduled throughout the month, during which questions were answered and concerns addressed. At the close of

the workshop, members were taken through the steps to vote on their priority populations. They discussed their choices in the small group and a small group score sheet was tallied. The three small group score sheets were tallied for the final priority setting scores. After feedback from the CDC Project Officer, the priorities were revised and people living with HIV and AIDS were incorporated into the priorities.

4.

Why is priority setting important?

Priority setting is a critical step in determining where to direct future resources to the people most at risk for HIV infections. Setting priorities is complex and challenging for community planning groups.

The RICPG is made up of over 20 people with varied backgrounds and experience. Many members have strong passions about the populations they want served. No one wants to say that one group is more important than another. In fact, everyone is important to all the members.

Think about it: most of us are at the table because we care about people. While the process of setting priorities can test and challenge us, we share the same goal of trying to decease the number of new HIV infections in all Rhode Islanders. Setting priorities is the main task of the RICPG and the community planning process' most important function. It is important that the members feel good about the process and at the same time feel sure that the people most in need are going to be served.

Intervention Priorities

The members were introduced to the second part of the workbook having to do with setting intervention priorities. (Appendix F: Welcome to Setting Priorities with the Rhode Island Community Planning Group for HIV Prevention)

Why is setting priorities for interventions important?

Setting intervention priorities is an important next step in directing future resources to the people most at risk for HIV infections. Like setting population/behavior priorities, it can be a complex and challenging undertaking. However, remember that we share the same goal of trying to decease the number of new HIV infections in Rhode Island. Making decisions on the interventions that most effectively reach our priority populations/behaviors can help us achieve lower future infection rates.

During the intervention priority setting training/discussion, the members were asked to consider the following questions:

- What is the best practice?
- What types of interventions are there?
- What criteria should the RICPG use to prioritize the interventions?

Criteria considered include the following:

1. **Interventions need to be clearly defined:** A clearly defined intervention is selected because it is a proven method for meeting the needs of the population/risk-behavior. The model is science-based and can be adapted by local communities. The intervention can clearly show how it was selected and how it will address the needs. The expected outcomes will lead to a decline in the cases of HIV infection.
2. **Interventions can be duplicated and maintain fidelity across sites:** The intervention needs a history of having been used consistently in several sites. There needs to be information about the steps the project staff can take to assure fidelity to the model. Good models have plans for training staff.
3. **Stability Over Time:** The intervention should structure activities in a timely, accurate, and consistent manner. The sequence of recruitment, client and group activities, and follow up must maintain a progression that makes sense. The RICPG member experience and expertise should be used to score this factor.
4. **Sufficient Reach:** Interventions should be able to reach the populations that it is targeting with culturally, ethnically, and linguistically appropriate activities, demonstrating an understanding of the population and/or the risk behavior targeted. The RICPG member experience and expertise should be used to score this factor.
5. **Sufficient Dosage:** The intervention provides a sufficient exposure to the activities to result in the intended outcomes. Interventions with limited client contact are less likely to result in measurable outcomes. The RICPG member experience and expertise should be used to score this factor.
6. **Obtainable Data:** Interventions should have opportunities to measure client response to the activities. Data collection methods and tools are important in proving an intervention is effective.

The RICPG used a two-step process to vote on the intervention priorities:

1. The group broke into small teams to discuss the best interventions for the priority populations that they represent.

2. The small groups scored the interventions for each of the priority populations. The small group votes were tallied to determine the final intervention priority.

In 2004 the RICPG was given more details about proven effective interventions and how they will be included into HEALTH-RI request for proposals in 2004. The final priorities were prepared incorporating the recommendations from CDC to make prevention for those who are HIV-positive the top priority. HEALTH-RI was able to do this and still maintain the integrity of the community planning process. The following matrix appeared in the RFP for HIV Prevention services:

Priority Populations & Interventions						
Priority Populations/Behaviors	**Intervention Priorities**					
HIV positive and high-risk men who have sex with other men and/or men who have sex with men and women	**HERR:Prevention Case Management /Rapid Testing**	**HIV Counseling, Testing & Referral**	**HERR: Individual Level Intervention/Rapid Testing**	**Targeted Outreach/Rapid Testing**	**HERR:Group Level Interventions/Rapid Testing**	**Comprehensive Syringe Exchange Program**
HIV positive and high-risk men and/or women who share injecting equipment and syringes	**HERR:Prevention Case Management/Rapid Testing**	**HERR:Individual Level Intervention/Rapid Testing**	**Comprehensive Syringe Exchange Program/Rapid Testing**	**HIV Counseling, Testing & Referral**	**Targeted Outreach/Rapid Testing**	**Group Level Interventions**
HIV positive and high-risk women who have unprotected sex and/or share syringes	**HERR:Individual Level Intervention/Rapid Testing**	**HERR: Group Level Interventions/Rapid Testing**	**Targeted Outreach/Rapid Testing**	**HIV Counseling, Testing & Referral**	**HERR:Prevention Case Management/RapidTTesting**	**Comprehensive Syringe Exchange Program**
HIV positive and high-risk youth who have unprotected sex and/or share syringes	**HERR:Individual Level Intervention/Rapid Testing**	**HERR:Group Level Interventions/Rapid Testing**	**HIV Counseling, Testing & Referral**	**HERR:Prevention Case Management/ Rapid Testing**	**Targeted Outreach/ Rapid Testing**	**Comprehensive Syringe Exchange Program**
HIV positive and high-risk individuals who do not know their serostatus	**HIV Counseling, Testing & Referral**	**Targeted Outreach/ Rapid Testing**	**Comprehensive Syringe Exchange Program/Rapid Testing**	**HERR:Prevention Case Management/ Rapid Testing**	**HERR:Group Level Interventions/Rapid Testing**	**Individual Level Intervention**